

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035035

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 303

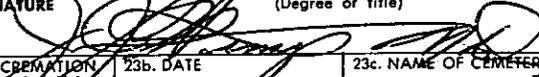
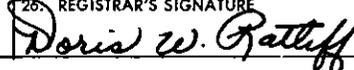
1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkville</b>	Length of stay in 1b <b>7 Da</b>	c. CITY OR TOWN <b>La Plata</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Grim Smith Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>BONNIE FAYE HOPPER</b>			4. DATE OF DEATH Month Day Year <b>Oct 12, 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 10 34</b>	9. AGE (last birthday) <b>24</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>2</b>	IF UNDER 24 HR Hours <b>--</b> Min. <b>--</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	11. BIRTHPLACE (City and state or country) <b>Fulton, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Lyle Ancell</b>		13b. MOTHER'S MAIDEN NAME <b>Viola E. Saling</b>		14. NAME OF HUSBAND OR WIFE <b>David Hopper</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>489-40-3304</b>	17. INFORMANT Address <b>David Hopper, La Plata, Mo.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>		<b>8 1/2 hrs.</b>
DUE TO (b) <b>Pneumonia, viral type unknown</b>		<b>60 hrs.</b>
DUE TO (c) _____		_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pregnancy, terminated 6 days ago</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I attended the deceased from **10-5-59** to **10-12-59** and last saw her <sup>her</sup> <sub>him</sub> alive on **10-12-59**  
Death occurred at **6:22 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE 		(Degree or title)	22b. ADDRESS <b>Kirkville, Missouri</b>		22c. DATE SIGNED <b>10-12-59</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Buried</b>	23b. DATE <b>Oct 14 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>La Plata Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>La Plata, Mo.</b>		
24. FUNERAL DIRECTOR <b>Wilson Funeral Home, La Plata, Mo</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Oct. 16. 1959</b>	26. REGISTRAR'S SIGNATURE 	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. J. Wimp, M.D.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Kenneth M. Wilson

Licensed Embalmer No. 4701

P. O. Address La Plata, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.