

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b	c. CITY OR TOWN Saint Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 956 Hamilton
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ADA Middle C. Hopkins Last Wickenden	4. DATE OF DEATH Month Sept Day 7 Year 1960
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5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months 2 Days 25	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Omaha, Nebraska	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Hopkins	13b. MOTHER'S MAIDEN NAME Catherine Evans	14. NAME OF HUSBAND OR WIFE Walter Wickenden
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT Address Bert Hopkins 773 Yale U. City, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 420.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. 	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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
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21. I attended the deceased from **12/43** to **9/7/60** and last saw her ^{her} ~~him~~ alive on **8/20/60**
 Death occurred at **3 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. Hayden M.D.	22b. ADDRESS 730 Hodiamouth	22c. DATE SIGNED 9-8-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9/10/60	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
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24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and sons 7233 Delmar	25. DATE RECD. BY LOCAL REG. SEP 8 1960	26. REGISTRAR'S SIGNATURE Loal Smith M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoen

Licensed Embalmer No. 3864

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.