

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Bloomfield.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		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 John Middle W. Last Hopkins	4. DATE OF DEATH Month November Day 2, Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min.	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) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Green Hopkins	13b. MOTHER'S MAIDEN NAME Katherine Cook	14. NAME OF HUSBAND OR WIFE Marinda Ann
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. Nil.	17. INFORMANT Address Marinda Ann Hopkins, Bloomfield, 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) <i>Myocardial Infarction</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
DUE TO (b) <i>Arteriosclerosis; Heart Disease</i>	
DUE TO (c) <i>Generalized Arteriosclerosis</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus, Greenian's disease</i>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) 420.0
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 10-31-60 to 11-2-60 and last saw ^{her} him alive on 11-2-60 Death occurred at 9:50 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John B. Meyer M.D.</i>	22b. ADDRESS 634 N Paul Blvd	22c. DATE SIGNED 11-3-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-4-60	23c. NAME OF CEMETERY OR CREMATORY Gravel Hill Cemetery	23d. LOCATION (City, town, or county) (State) Stoddard County, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc.	ADDRESS 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. NOV 3 1960	26. REGISTRAR'S SIGNATURE <i>Paul Blod</i>
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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 Elton H. Pen

Licensed Embalmer No. 42

P. O. Address St. L.

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