MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-015256
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3674

FILED APR 25 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in Ib: 2 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Missouri Baptist
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois
b. COUNTY: St. Clair
c. CITY OR TOWN: Caseyville
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 517 N. Long
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First ERNEST Middle H. Last HOPKE
4. DATE OF DEATH: Month April Day 16 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-27-1880
9. AGE (last birthday): 80
IF UNDER 1 YEAR: Months 11 Days 19
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Man
10b. KIND OF BUSINESS OR INDUSTRY: Burlington R.R.
11. BIRTHPLACE (City and state or country): Hartford, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: deceased Stella Francis (Sheets)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Joyce Gardner, West Plains, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bleeding prepyloric & pyloric ulcer
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ulceration of gastric mucosa
DUE TO (c) 540.0
INTERVAL BETWEEN ONSET AND DEATH

Joseph M. Liss
Joseph Lieberbi

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Leftventricular hypertrophy

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 4/15/61 to 4/15/61 and last saw ~~him~~ her alive on
Death occurred at 11:45 a.m. 4/16/61 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William R. Platt, M.D.
22b. ADDRESS: 919 N. Taylor Ave St Louis 8 Mo.
22c. DATE SIGNED: 4/17/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-18-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State): Belleville Illinois

24. FUNERAL DIRECTOR ADDRESS: C. G. Kurrus, Jr - E.St.Louis
25. DATE RECD. BY LOCAL REG.: APR 17 1961
26. REGISTRAR'S SIGNATURE: Hoad Smith M.D.

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. Mo. 3162

P. O. Address E. St. Louis, Illinoi

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.