

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032089  
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 237

AMENDED

FILED OCT 5 1961

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>12 Hrs</u>	c. CITY OR TOWN <u>Fulton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Callaway Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>823 High St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Althea</u> Middle <u>Vesta</u> Last <u>Hopkins</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/1879</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Gallaway Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>Joseph A. Dearing</u>	13b. MOTHER'S MAIDEN NAME <u>Emily Susan Ferguson</u>	14. NAME OF HUSBAND OR WIFE <u>Edgar W. Hopkins</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	17. INFORMANT Address <u>Mrs. Dorothy Grothaus Fulton, Mo</u>
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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) <u>Metastatic Carcinoma Breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
DUE TO (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) <u>Hypertensive Cardiovascular Disease</u>		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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>  </u>
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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 1956 to present and last saw her him alive on Sept 27, 1961  
Death occurred at 7:45 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James E. Hite MD</u>	22b. ADDRESS <u>Fulton, Mo</u>	22c. DATE SIGNED <u>10-3-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 2, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>S. Callaway Co Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Wallace Funeral Home Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 3-1961</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

1961 9 100

**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 *A. R. Masune*

Licensed Embalmer No. 4996

P. O. Address Fulton 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.