

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-042530

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO.

BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11095 STATE FILE NUMBER

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b		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>3705 Cote Brillante</u>		d. STREET ADDRESS (If outside, give location) <u>3705 Cote brillante</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>HOPSON</u> Last			4. DATE OF DEATH Month <u>NOV.</u> Day <u>26</u> Year <u>1961</u>		
--	--	--	--	--	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/29/92 69</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	------------------------------------	---	---------------------------------------	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country) <u>LAUDERDALE, MISS U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY
--	-----------------------------------	---	-----------------------------

13a. FATHER'S NAME <u>JIM SLOAN</u>	13b. MOTHER'S MAIDEN NAME <u>Betty Burton</u>	13c. NAME OF HUSBAND OR WIFE <u>MIKE HOPSON</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>MIKE HOPSON; 3705 Cote Brillante</u>	Address
---	---------------------------------------	--	---------

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>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>---</u>		
DUE TO (c) <u>420.1</u>		

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.) <u>---</u>
---	---	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>0</u>	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.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY	STATE
--	--	--	--	--------	-------

21. I attended the deceased from 11/20/61 to 11/26/61 and last saw her/him alive on 11/20/61.
Death occurred at 12 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>House N. Little M.D.</u>	(Degree or title)	22b. ADDRESS <u>3167 Sheridan Avenue</u>	22c. DATE SIGNED <u>11/27/61</u>
---	-------------------	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FATHER DICKSON</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS CO., MO</u>	(State)
---	-----------------------------	---	---	---------

24. FUNERAL DIRECTOR <u>W. ROBINSON & SONS. 290 FRANKLIN</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>NOV 29 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>
---	---------	--	--

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 Eugene M. Miles

Licensed Embalmer No. 3623

P. O. Address 2911 Ave

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.