

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035246
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1776

DO NOT WRITE ON THIS STUD AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 48 DAYS	c. CITY OR TOWN PARAGOULD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 610 SOUTH EIGHTH AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLIE CHRISTOPHER HOPPER			4. DATE OF DEATH Month Day Year SEPTEMBER 14 1963
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 12-12-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAFE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY CAFE	9. AGE (last birthday) 64 IF UNDER 1 YEAR Months Days 9 2 IF UNDER 24 HR Hours Min. 9 2
11a. BIRTHPLACE (City and state or country) GREENE COUNTY, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME HENRY HOPPER		13b. MOTHER'S MAIDEN NAME ELIZABETH TOMLINSON	14. NAME OF HUSBAND OR WIFE FANNIE HOPPER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, as unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OBSTRUCTIVE PULMONARY EMPHYSEMA			INTERVAL BETWEEN ONSET AND DEATH 94 15 YEARS <i>Roby</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)			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
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.)	
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
21. I attended the deceased from <u>July 5, 1963</u> to <u>Sept. 14, 1963</u> and last saw him on _____ Death occurred at <u>8:05 a.m.</u> on the date stated above, and, to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. S. Cohen</i> R. S. COHEN, M.D., Chief, Medical Service		22b. ADDRESS VA HOSPITAL, Poplar Bluff, Mo.	22c. DATE SIGNED 9-16-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 17, 1963	23c. NAME OF CEMETERY OR CREMATORY Linwood	23d. LOCATION (City, town, or county) (State) Paragould Greene Ark.
24. FUNERAL DIRECTOR Heath Funeral Home, Paragould, Ark.		25. DATE RECD. BY LOCAL REG. 9/18/1963	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>

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 Verlyn L. Heath

Licensed Embalmer No. 5169

P. O. Address Paragonel, Ark.

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.