

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

14568

1. PLACE OF DEATH

County Jackson Registration District No. 300
Township Rain Primary Registration District No. 1002
City St. Joseph (No. St. Joseph Hosp)

File No. 1582
Registered No. 1582
St. _____ Ward _____

2. FULL NAME

Miss Rosa Hopfinger
(a) Residence. No. 3827 Harrison St., _____ Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? _____ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>✓</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 15th 1892</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>46</u>	<u>10</u>	<u>16</u>	<u>16</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work. <u>At Home</u>				
(b) General nature of industry, business, or establishment in which employed (or employer). <u>✓</u>				
(c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ill

PARENTS	10. NAME OF FATHER <u>Thos Hopfinger</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Ill</u>
	12. MAIDEN NAME OF MOTHER <u>Mary Weibler</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Ill</u>

14. INFORMANT Miss Rosa Hopfinger
(Address) 3827 Harrison

15. FILED 4/1 1929 M. M. Conroe REGISTRAR
Ann

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/1/29 1929
17. I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to April 1, 1929 that I last saw her alive on April 1, 1929 and that death occurred, on the date stated above, at 6:40 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

54-B Pelvic Peritonitis
190 C
190 (duration) _____ yrs. mos. ds.
CONTRIBUTORY Hysterectomy - Fibroid
(SECONDARY) uterus (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF March 25, 1929
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical & Chemical Exam
(Signed) R. L. Underwood, M. D.
4/1, 1929 (Address) 212 North 2nd St. K.C., Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mountrose mo DATE OF BURIAL 4/2/29 1929

20. UNDERTAKER H. J. Mayberry ADDRESS City mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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J. W. Anderson
Bright Bldg
Li 8347