

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Joseph
(b) City or town St. Joseph
(c) Name of hospital or institution State Hospital #2
(d) Length of stay: In hospital or institution 2 mos 5 days
In this community yes

3. (a) PRINT FULL NAME

Elora Hopes

3. (b) If veteran,

name war

No

3. (c) Social Security

No.

Not

4. Sex Female

5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

Oscar Hopes

6. (c) Age of husband or wife if

alive

years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

48

10

24

hr. min.

9. Birthplace

Clay

Mo

10. Usual occupation

Housework

11. Industry or business

at home

12. Name

Charlie Bird

13. Birthplace

Clay

Mo

14. Maiden name

Rebecca Walter

15. Birthplace

Clay

Mo

16. (a) Informant

Oscar Hopes

(b) Address

405 No. 1st St. Liberty Mo

17. (a) Burial, cremation, or removal

Burial

(b) Date thereof

Jan 26 1944

(c) Place: burial or cremation

Liberty Mo

18. (a) Signature of funeral director

Liberty

(b) Address

Liberty

19. (a) Date received local registrar

7/26/44

(b) Registrar's signature

Delaney

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay
(c) City or town Liberty
(d) Street No. 405 No. 1st
(e) Citizen of foreign country? No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7/23 day 1 year 1944 hour 1:45 minute A M.

21. I hereby certify that I attended the deceased from May 18 1944 to July 23 1944
that I last saw her alive on July 23 1944
and that death occurred on the date and hour stated above

Immediate cause of death Paresis of the brain Duration 4 days

Due to Paresis of the brain I don't know the duration

Due to Neuman 4 + Kahn 4 + 526-44
colloidal tested 55544330

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 309
Of autopsy no autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(c) Means of injury
23. Signature B. E. Cassin (M. D. or other)
Address State Hospital #2 St. Joseph Date signed 7/23/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3311

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.