

MAY 23 1935 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12291

1. PLACE OF DEATH

25 County *Clyde*
Township *Shoals*
City (No.) (No.) St. Ward)

Registration District No. *204*
Primary Registration District No. *5782*

File No.
Registered No. *20*

2. FULL NAME *Marcus Gill Hopper*

(a) Residence, No. St. Ward.
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Jane Hopper</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Sept. 19. 1860</i>		
7. AGE	YEARS <i>74</i>	MONTHS <i>6</i>
	DAYS <i>16</i>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>farmer</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>retired</i>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Apr. 5. 1935*

22. I HEREBY CERTIFY, That I attended deceased from *July* 19*32* to *April 5* 19*35*
I last saw him alive on *April 18* 19*35*. Death is said to have occurred on the date stated above, at *5:30* p.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage - Apoplexy
Date of onset *4/5/35*

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) *Ch. Compton* (Address) *Cameron Mo.*

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	13. NAME <i>Riley Hopper</i>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Kentucky</i>
	15. MAIDEN NAME <i>Owens</i>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	17. INFORMANT (ADDRESS) <i>Clarence Hopper Cameron Mo</i>
	18. BURIAL, CREMATION, OR REMOVAL <i>Hopewell Am. Co. Apr. 7 1935</i>
	19. UNDERTAKER (ADDRESS) <i>W. Polaud Cameron Mo</i>
	20. FILED <i>4/6 1935 WCH Riley Registrar</i>

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

