

FILED MAR 2 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5809  
1666

318

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN				c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		d. STREET ADDRESS (If rural, give location)		
d. FULL NAME OF HOSPITAL OR INSTITUTION										
3. NAME OF DECEASED (Type or Print) a. (First)			b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
5. SEX			6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years) (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)							
			ANTECEDENT CAUSES							
			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
			DUE TO (c)							
			II. OTHER SIGNIFICANT CONDITIONS							
			Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)		(STATE)				
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?						
22. I hereby certify that I attended the deceased from <u>20 Sept, 1951</u> to <u>18 Feb, 1951</u> , that I last saw the deceased alive on <u>18 Feb, 1951</u> , and that death occurred at <u>3:35 a. m.</u> , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title)				23b. ADDRESS			23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify)				24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)		
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			

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

2009

FEB 19 1951

Albert H. Hoppe

Albert H. Hoppe, 4700 Washington Blvd.

**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 .....  
Student Embalmer

Signed

*J. Wm. Dumbally*  
3637

Licensed Embalmer No. \_\_\_\_\_

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.