

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

Do not use this space.

3509

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hospital)

File No.

Registered No. 1150

St. Ward)

2. FULL NAME

(a) Residence. No. 1447 1/2 Jordan St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Henry Koppman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 1884

7. AGE YEARS 47 MONTHS 8 DAYS 4 IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Matron
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis

10. NAME OF FATHER Domonik Ralph

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

14. INFORMANT Dr. ...
(Address) City Hospital

15. FILED JAN 31 1928
19..... Mar. 6 Starroff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 26, 1928, to Jan 28, 1928, that I last saw him alive on Jan 26, 1928, and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute bursitis (left knee)
(streptococcus)

36
156A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Septicemia (streptococcus)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 47
IF NOT AT PLACE OF BIRTH.....

8 **DID AN OPERATION PRECEDE DEATH?**..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
11 (Signed) Edmund R. Sheridan, M.D.
29, 1928 (Address) City Hospital

*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 Valhalla Crematory **DATE OF BURIAL**, 2/1 1928

20. UNDERTAKER W.A. Stock M.D. Co. **ADDRESS** 2117 E. Grand

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

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.

Kaplan