

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

Do not use this space.

30497

1. PLACE OF DEATH

County Franklin
Township _____
City Washington (No. _____)

Registration District No. 297
Primary Registration District No. 3016

File No. _____
Registered No. 94
St. _____ Ward)

2. FULL NAME

Daniel Kopp
(a) Residence. No. Farm residence St. _____
(Usual place of abode)

Length of residence in city or town where death occurred 12 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Annie Kopp
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 12 - 1850
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 7 7
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Baden (STATE OR COUNTRY) Germany
10. NAME OF FATHER Theo Kopp
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Baden - Germany
12. MAIDEN NAME OF MOTHER Mariana Wintermacher
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Baden Germany

14. INFORMANT Edward Kopp (Address) Washington Mo.

15. FILED Sept 21 1929 O. L. Muench REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1929
17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Sept 19, 1929, that I last saw him alive on Sept 15, 1929 and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
115 (duration) yrs. 1 mos. 5 ds.
CONTRIBUTORY Influenza (SECONDARY) (duration) yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED Place of death
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS No
(Signed) J. S. Mansfield M. D.

*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 Catholic Ceme DATE OF BURIAL 9/21/29

20. UNDERTAKER Niburg & Vith, Washington Mo. ADDRESS _____

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.

ORIGINAL RESERVED FOR BINDING

102
OCT 23 1929

