

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

Do not use this space.

14061

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 5800, Arsonal Sam., St. _____ Ward _____)

File No. _____
 Registered No. 3387

2. FULL NAME

August Sopp
 (a) Residence. No. 5800 Arsonal St. 13 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
abt 70 Unknown or _____

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

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

10. NAME OF FATHER Andrew Sopp

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Margi E. Geyer
 (Address) St. Louis

15. FILED 4 1930 Max C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-3 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-1, 1930 to 4-3, 1930 that I last saw h. un alive on 4-3, 1930, and that death occurred, on the date stated above, at 5 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis

730
 CONTRIBUTORY (SECONDARY) 900
 (duration) _____ yrs. _____ mos. _____ ds.
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) B. K. Hill M. D.
4-4-30 (Address) 5600 Arsonal

*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 St. Peters Cemetery DATE OF BURIAL April 5 1930

20. UNDERTAKER Henry Ridner and Co ADDRESS 1417 N. Market St.

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.

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