

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

Do not use this space.

14310

File No. _____
Registered No. **3650**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St Louis Mo** (No. **5010 2**, **Easton Ave**)

2. FULL NAME

George Kopf
(a) Residence, No. **5010 2 Easton Ave**, St. **6** Ward. (If nonresident, give city or town and State)
(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.

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 **Mary M Kopf**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **10-20-1861**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	68	5	21	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

10. NAME OF FATHER **Valentine Kopf**

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

12. MAIDEN NAME OF MOTHER **Don't know**

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

14. INFORMANT **Mary M. Kopf**
(Address) **5010 2 Easton Ave**

15. **APR 12 1930** FILED **W. C. [Signature]** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-11 1930**

17. **No Physician in Attendance**
HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h..... alive on _____, 19____, and that death occurred, on the date stated above, at **10:20 P.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
930
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **900**
(duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **J. W. Kerner**, M.D.
4/12 1930 (Address) **Dep. Coroner**

*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 **S S Peter + Paul Ch** DATE OF BURIAL **4-14 1930**

20. UNDERTAKER **Weick Bros 2201 S Grand** ADDRESS

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.

