

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

Do not use this space.

14524

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township St. Louis Primary Registration District No. 1003 File No. ....  
 City St. Louis (No. SOLATION HOSPITAL) Registered No. 3872  
 St. 11th Ward)

**2. FULL NAME**

(a) Residence. No. 915 N. Taylor St. 11th Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 39 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) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 24, 1855  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
74 7 24  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work motorman  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ohio (STATE OR COUNTRY)  
 10. NAME OF FATHER Valentine Cupp  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Hanna Winter  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio (STATE OR COUNTRY)

14. INFORMANT Lorraine Kroner  
 (Address) SOLATION HOSPITAL  
 15. FILED APR 18 1930 REGISTRAR Wm. C. Starkey

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-17 1930  
 17. I HEREBY CERTIFY, That I attended deceased from 4-3, 1930, to 4-17, 1930 that I last saw him alive on 4-17, 1930, and that death occurred, on the date stated above, at 6:10 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic myocarditis  
90B 93C  
150? yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) myocardial infarction  
17 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) W. K. Kibbel, M. D.  
4-18, 1930 (Address) SOLATION 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 Columbus Ohio DATE OF BURIAL April 21 1930  
 20. UNDERTAKER Philander Craig Washington ADDRESS HH 68

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.

