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.

SEP 18 19

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

Do not use this space.

30545

1. PLACE OF DEATH

County: St Charles — Registration District No.: 757 — File No.:

Township: — Primary Registration District No.: 3036 — Registered No.: 139

City: St Charles (No. St. Joseph's Hospital St. Ward)

2. FULL NAME: Ferdinand Kopmann

(a) Residence, No. 1415 Sr. 3rd St., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ida Hemsath

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May 10th 1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	69	3	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year): 11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Augusta Mo

FATHER

13. NAME: Lucas Kopmann

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

MOTHER

15. MAIDEN NAME: Elizabeth Strickhoff

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

17. INFORMANT (ADDRESS): Henry Kopmann, Augusta, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Augusta Mo DATE: Aug 13th 1934

19. UNDERTAKER (ADDRESS): H. Gallemyre & Sons Co, 700 N. 2nd St.

20. FILED 8/13 1934 Clarence G. Fr Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug 11, 1934

22. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1931, to Aug 11, 1934

I last saw ~~him~~ alive on Aug 11, 1934. Death is said to have occurred on the date stated above, at 9:45 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lung Abscess	15 yrs ago
Chr. Empyema	
23A	
10A	
14B	

Other contributory causes of importance:

Name of operation: — Date of:

What test confirmed diagnosis? Phys. Exam Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) B. Gerst Gasson, M. D.

(Address) 200 Clay St. St. Charles, Mo

#2 St. Charles.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

139

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Ferdinand Kopmann

Who died at _____ on Aug-11-1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W ~~Single, married~~, widowed ~~or divorced:~~ _____

Date of birth _____ Age: Years 69 Months 3 Days 1

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Lung abscess, Chr. empyema Tuberculosis 2 2

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Clarence R. Wheeler Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh
State Registrar

Reg. Dist. No. 757

Primary Reg. Dist. No. 3036

Special Agent.

S-30545

S-30545