

Registration District No. **297**

Primary Registration District No. **3016**

Registrar's No. **96**

1. PLACE OF DEATH: **1**
(a) County **Franklin**
(b) City or town **Washington**
(c) Name of hospital or institution: **St. Frances Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 days**
In this community **83 yrs. 9 mo. 21 da.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **HENRY KOPP 10-71**
3. (b) If veteran, name war **V**
3. (c) Social Security No. **V**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mary Gertrude Kopp** 6. (c) Age of husband or wife if alive **Deceased** years
7. Birth date of deceased **January 31 1856**
(Month) (Day) (Year)

8. AGE: Years **83** Months **9** Days **21** If less than one day hr. min.

9. Birthplace **Washington Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business **Farming**

MOTHER FATHER
12. Name **Daniel Kopp**
13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **My John Proege**

(b) Address **Washington, Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov 25 1939**
(Month) (Day) (Year)

(c) Place: burial or cremation **Washington, Mo.**

18. (a) Signature of funeral director **Nicholas Witt, Inc.**
(b) Address **Washington, Missouri**

19. (a) **Nov 24 1939** (Date received local registrar) (b) **A.A. May** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Franklin**
(c) City or town **Washington**
(If outside city or town limits, write "RURAL")
(d) Street No. **118 E. Second St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **V** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **22** nd
year **1939** hour **10** minute **35** P. M.
21. I hereby certify that I attended the deceased from **Nov. 17**
19 **29**, to **Nov. 22**, 19 **39**
that I last saw him alive on **Nov. 22**, 19 **39**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute cardiac decompensation, following Appendectomy and Cholecystectomy**
Due to **Cholecystectomy**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____
28. Signature **C. P. ...** (M. D. or other) _____
Address **Washington, Mo.** Date signed **11/24/39**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1021

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
Me Lester H. Vitt., Registered Apprentice No.....
working under my personal supervision.

Signed *Lester H. Vitt*
Licensed Embalmer No. *3254*
P. O. Address *Washington, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

39537
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 297
(b) Township Washington Primary Registration District No. 3016 Registered No. _____
(c) City Washington (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Henry Kapp
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 9 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as 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) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____, 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 22 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

acute Cardiac De
compensation following
appendectomy and
cholecystectomy
Date of onset _____

Other contributory causes of importance:
acute appendicitis 1/21
& a gangrenous
Gall Bladder.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? _____

If so, specify _____

(Signed) J. P. Post, M. D.

(Address) Washington Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

SUPPLEMENT

