

S. No. 2
-11-10-39
5-17-39
P. I. X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20443**
Registrar's No. **5391**

Registration District No. **791** Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(c) Name of hospital or institution:
3913 St. Ferdinand Ave.
(d) Length of stay: In hospital or institution _____
In this community **50** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **3913 St. Ferdinand Ave.**
(e) If foreign born, how long in U. S. A.? **50** years.

3. (a) PRINT FULL NAME **Julia E Schopp**
(b) If veteran, name war **No**
(c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **21**
year **1940** hour **4** minute **45 A.** M.

4. Sex **Female**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Joseph F. Schopp**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 9, 1888** **1859**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 10**, 19**40**, to **June 21**, 19**40**
that I last saw her alive on **June 20**, 19**40**
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

8. AGE: Years **81** Months **0** Days **12**
If less than one day _____ hr. _____ min.

Chronic myocarditis
Chronic arteriosclerosis
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **None**
Of autopsy **None**

9. Birthplace **Trenton** **Illinois**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**
11. Industry or business _____
12. Name **John Zimmermann**
13. Birthplace **Switzerland**
14. Maiden name **Mary Ging**
15. Birthplace **Switzerland**

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Rose M. Schopp**
(b) Address **3913 St. Ferdinand Ave.**
17. (a) **Burial** (b) Date thereof **6/24/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peter & Paul**
18. (a) Signature of funeral director _____
(b) Address **2117 E. Grand Blvd.**
19. (a) **JUN 23 1940** (b) **J. F. Predeck**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **None**
(b) Date of occurrence **None**
(c) Where did injury occur? **None**
(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 **None**
23. Signature **S. M. F. Namann** (M. D. or other)
Address **27437 Grand** Date signed **6/21/40**

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Alfred J. Boedeker

Licensed Embalmer No. 2663

P. O. Address 4204 Baine

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.)