DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 8 [redacted]

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3069

State File No. 26093

Registrar's No. 1809

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)

In this community: Unknown

2. USUAL RESIDENCE OF DECEASED: 007

(a) State: Missouri (b) County: 17

(c) City or town: St. Louis, 9
(If outside city or town limits, write "RURAL")

(d) Street No.: 4006 Hydraulic Ave.
(If rural, give location)

(e) Citizen of foreign country? --- (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Herman D. Koop

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Elizabeth Koop

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: August (Month) 11, (Day) 1857 (Year)

8. AGE: Years 85 Months 11 Days 24 If less than one day: hr. min.

9. Birthplace: Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Henry Koop
13. Birthplace: Unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant: Laura Koop
(b) Address: 4006 Hydraulic Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8 6 43 (Month) (Day) (Year)

(c) Place: burial or cremation: Oak Grove Mausoleum

18. (a) Signature of funeral director: Baker Heberle Funeral Co.

(b) Address: 3634 Bravoos Avenue

19. (a) AUG 6 1943 (Date received by local registrar) (b) C. L. McClaren M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4, year 1943 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 1, 1938, to Aug 4, 1943, that I last saw him alive on Aug 3, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchiectasis	10 yrs
Arteriosclerosis	10 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Nephritis	

Major findings:
Of operations:

Of autopsy:

PHYSICIAN — 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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: H. M. Irvine (M. D. or other)

Address: 3115 S. Grand Date signed: 8/5/43

707 (Licensed Embalmer's Statement on Reverse Side)

AUG 18 1943

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.....Frank J. Clyne

Licensed Embalmer No.....264

P. O. Address.....St Louis Mo

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

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—5-43
I X36930

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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1809

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Herman D. Koop.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 11 (Day) 1857 (Year)

8. AGE: Years 85 Months 11 Days 28 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 4
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchiectasis arteriosclerosis	
Due to	
Due to	
Other conditions nephritis chronic (Include pregnancy within 3 months of death)	
Cause (Bronchiectasis	

Major findings:
Of operations
Of autopsy 131 b

PHYSICIAN
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature N M Lerner (M. D. ~~or other~~)
Address 3115 S Grand Date signed

SUPPLEMENTARY

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

86092-5

APR 24 1944