V. S. No. 2
00M—8-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31821

State File No. 0

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1963

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Ballwin Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pine Crest Home 4
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ballwin 96
(If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME Philomena Schopp

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

3. (c) Social Security No.

4. Sex Female

5. Color or race White 2

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

6. (b) Name of husband or wife Adolph

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

7. Birth date of deceased February (Month) 2 (Day) 1872 (Year)

8. AGE: Years 72 Months 7 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) Austria 4 (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Joseph Tappenier 5
13. Birthplace (City, town, or county) Switzerland 5 (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace (City, town, or county) Austria 4 (State or foreign country)

16. (a) Informant Albert Schopp
(b) Address c/o City Sanitarium St. Louis Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director John H. Gibbon Sons
(b) Address 2630 Gravois Ave.

19. (a) SEP 25 1944 (Date received local registrar) (b) E. G. McGarvey MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 20
year 1944 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from August 2, 1944, to September 19, 1944;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Chronic Myocarditis (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 93d	

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 R. W. Jensen (M. D. ~~or other~~)

Address Manchester Mo. Date signed 9/21/44

(Licensed Embalmer's Statement on Reverse Side)

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 Robert L. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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, fact should be so stated above.