

No. 2
-12-45
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED 8801 1946
STANDARD CERTIFICATE OF DEATH

35308

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8692**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ST. ANTHONY Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME **MARY KOPFF**

3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex **Female** **5. Color or race** **white** **6. (a) Single, widowed, married, divorced** **single**

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

7. Birth date of deceased **10 - 9 - 1946**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			8 hrs min.

9. Birthplace **ST. LOUIS**
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name **SYLVESTER KOPFF**
13. Birthplace **ST LOUIS**
(City, town, or county) (State or foreign country)
14. Maiden name **AGNES BENT**
15. Birthplace **ST LOUIS**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sylvester Kopff**
(b) Address **4128 Humphrey St**

17. (a) BURIAL **(b) Date thereof** **OCT. 10 - 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **old ss Peter + Paul**

18. (a) Signature of funeral director **Thomas J. Fox**

(b) Address **2906 Gravois Ave**

19. (a) (Date received from Registrar) **OCT 10, 1946** **(b) (Registrar's signature)** **J. F. Bredak**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4128 Humphrey St - 9**
(if rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **9**
 year **1946** hour **11** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **10.9.46**
 19..... to **10.9.46** 19.....
 that I last saw her alive on **10.9.46** 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death..... **Premature Infant 7 mo**
 Duration.....
157
 Other conditions..... **Congenital Heart disease**
(Include pregnancy within 5 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

23. Signature **J. F. Bredak** (M. D. or other) **M.D.**
Address **2602 S. Grand** **Date signed** **10.9.46**

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

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 *David Van Fossan*

Licensed Embalmer No. *4242*

P. O. Address *7906 Hiawatha*

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.