

FILED APR 11 1948

Registration District No. 310

Primary Registration District No. 5038 3508

Registrar's No. 59

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
622 South 8th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 70 years (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Charles
(c) City or town St Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 622 South 8th St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elisa Koper

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

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Joseph Koper 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 17 1867
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation unemployed

11. Industry or business _____

12. Name Stephan Diekmann

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

14. Maiden name Unknown

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

16. (a) Informant Arthur Koper

(b) Address 622 South 8th St

17. (a) Burial (b) Date thereof March 11 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St John's Cemetery

18. (a) Signature of funeral director Hackmann Rau

(b) Address St Charles Mo.

19. (a) 3-30-48 (b) Frankie Hamilton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1948 hour 7 minute 0 M.

21. I hereby certify that I attended the deceased from April 2 1948 to March 7 1948
that I last saw her alive on March 6 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis Heart Disease Duration ?

Due to Arteriosclerosis

Due to _____

Other conditions Diabetes Mellitus ?
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 61

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature Jim Jenkins (M. D. or other) _____

Address St Charles Mo Date signed 3-10-48

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

92
9
3
0

MOTHER FATHER

RECEIVED
District Officer No. 9,
District File No. _____
Date Filed APR 12 1948

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.....

Charles J. Macker, Registered Apprentice No. *414*
working under my personal supervision.

Signed..... *Arthur C. Bane*

Licensed Embalmer No. *3155*

P. O. Address..... *St Charles 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

State File No. apul
Registrar's No. 0-9

Registration District No. 310 Primary Registration District No. 3058

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(c) Name of hospital or institution:
(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 Elsie K. Koper
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid

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

7. Birth date of deceased July 19 1908
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Invalid for years

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March 7
year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____
to _____ 19____
that I last saw h. _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
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 _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

S-9872