

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **Saint Louis**
(b) City or town **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Park Lane Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **0**
(Specify whether years, months or days)
In this community **0**

3. (a) PRINT FULL NAME **Ethel May Kupper**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ernest A. Kupper** 6. (c) Age of husband or wife if alive **68** years
7. Birth date of deceased **August 16-- 1884**
(Month) (Day) (Year)

8. AGE: Years **63** Months **11** Days **16** If less than one day hr. min.

9. Birthplace **Cedar Falls, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business **George E. Sheerer**
12. Name **Unknown** **Iowa**
13. Birthplace **Amelia** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown** **Iowa**
15. Birthplace **Ernest A. Kupper** (City, town, or county) (State or foreign country)

16. (a) Informant **7847 Gannon Ave**
(b) Address

17. (a) **Removal** (b) Date thereof **8/4/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burlington, Iowa**
C.R. Lupton & Sons

18. (a) Signature of funeral director **7233 Delmar Blvd**
(b) Address

19. (a) **AUG 4 - 1948** (b) **J. F. Buddeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **University City**
(If outside city or town limits, write "RURAL")
(d) Street No. **7847 Gannon Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH **August 2nd 1948**
Month **August** day **2nd** year **1948** hour **9** minute **45** M.

21. I hereby certify that I attended the deceased from **July 29** to **Aug 2**, 1948

that I last saw him alive on **Aug 2**, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** Duration

Due to **Hypertension**

Due to **83**

Other conditions **83**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 (Specify type of place) (e) Means of injury
23. Signature **Walter S. Shaver** (M. D. or other) **Indell Trust Bldg** Date signed **Aug 2 1948**

2739 N. Grand Blvd
Je. 4271
Hours 2-6 Daily

6834

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

Arnold W. Schoene

Licensed Embalmer No.

3864

P. O. Address

St. Louis, 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.