

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21645

State File No. 5130

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Collinsville	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns Hospital		d. STREET ADDRESS N.R.	
3. NAME OF DECEASED (Type or Print) Edward A Schoppe		4. DATE OF DEATH (Month) (Day) (Year) June 11 1949	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb 26 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Manager		10b. KIND OF BUSINESS OR INDUSTRY Globe Democrat	9. AGE (In years last birthday) 49
11. BIRTHPLACE (State or foreign country) Columbia Illinois		12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Leonard Schoppe	13b. MOTHER'S MAIDEN NAME Lena Schoening	14. NAME OF HUSBAND OR WIFE Bertha
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 489-07-6565	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bertha Schoppe Collinsville Ill

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Apoplexy		
ANTECEDENT CAUSES	DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 820
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 334X

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 4:00 P. m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Patrick E Taylor Coroner	22b. ADDRESS 1500 Clark	22c. DATE SIGNED 6-13-49
23a. BURIAL, CREMATION, REMOVAL	23b. DATE 6-13-1949	23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) Collinsville Illinois		

DATE REC'D BY LOCAL REG. JUN 14 1949	REGISTRAR'S SIGNATURE J. B. Parson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 4164 Manchester Ave.
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5150

*Must*

**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 \_\_\_\_\_

..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed *J. Allen Davis Jr*  
Licensed Embalmer No. *4053*  
P. O. Address *J. Davis*

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

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