

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

25189
 6045

FILED JUL 25 1949

State File No. _____
 Registrar's No. _____

#98655

318

1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. - If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 23 - 1224 Sidney St	
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) POPP c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 8th, 1949
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH Mch 31 1900
9. AGE (In years last birthday) 49		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) welder	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hungary 4		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Mike Popp		13b. MOTHER'S MAIDEN NAME Esthel Daskel	14. NAME OF HUSBAND OR WIFE Anna
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna Popp 1224 Sidney St
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		-MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>aspiration</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Mycarditis</u>	
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) 107	
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? 491X	
22. I hereby certify that I attended the deceased from 6/20/49 19__, to 7/8/49 19__, that I last saw the deceased alive on 7/8/49 19__, and that death occurred at 8:15pm, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Clara Anne Taylor M.D.</u>		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 7/9/49
24a. BURIAL, CREMATION REMOVAL (Specify) removal	24b. DATE 7-9-1949	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Duquoin Ill
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 11 11 1949 <u>J. B. Lester</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Svc 4104 Manchester		

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

6045

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 Ronald O. Salunka

Licensed Embalmer No. 3917

P. O. Address St. Louis 10. 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.