

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 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) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 21 720 N. 20th Street	

3. NAME OF DECEASED (Type or Print) a. (First) Emil	b. (Middle) H.	c. (Last) KOEPP	4. DATE OF DEATH (Month) (Day) (Year) Sept. 21st, 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 29, 1871	9. AGE (In years last birthday) 79	10 UNDER 1 YEAR Months	10 UNDER 1 YEAR Days	10 UNDER 1 YEAR Hours	10 UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk	10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (State or foreign country) Carlinville, Illinois	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME F. Frederick Koopp	13b. MOTHER'S MAIDEN NAME Johanna Rathke	14. NAME OF HUSBAND OR WIFE Levannie Koopp
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Edith Freeman	ADDRESS 614 Audobon
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease & Congestive Failure 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 type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 443X
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22. I hereby certify that I attended the deceased from 7/30/50, 19, to 9/21/50, 19, that I last saw the deceased alive on 9/21/50, 19, and that death occurred at 3:58PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dorland A. Miller, M.D.	23b. ADDRESS 1515 Lafayette Ave.	23c. DATE SIGNED 9/22/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 9/22/1950	24c. NAME OF CEMETERY OR CREMATORY Gillispie	24d. LOCATION (City, town, or county) (State) Illinois
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DATE REC'D BY LOCAL REG. SEP 22 1950	REGISTRAR'S SIGNATURE J B Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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WRITE PLAINLY—USING 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 me

working under my personal supervision.

Student Embalmer No.....

Signed.....

*Wm S. Salters*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4699

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.