FILED MAY 25 1953

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19127

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6072 Registrar's No. 173

1. PLACE OF DEATH
a. COUNTY: St. Francois
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Doe Run
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Francois
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Doe Run 094
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Anthony
b. (Middle): Propst
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): May 15 1953

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Aug 3 1888
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months 9 Days 12 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Missouri natural Gas Co
10b. KIND OF BUSINESS OR INDUSTRY: employee
11. BIRTHPLACE (State or foreign country): Bollinger County Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Daniel Propst
13b. MOTHER'S MAIDEN NAME: Susan Richards
14. NAME OF HUSBAND OR WIFE: Verline Propst

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.: 486-14-2188
17. INFORMANT'S SIGNATURE OR NAME: Verline Propst — ADDRESS: Doe Run Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 or 3 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
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: 4201
20. AUTOPSY? YES ☐ NO ☒

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1, 1953, *to* May 15, 1953, *that I last saw the deceased alive on* 5-14, 1953, *and that death occurred at* 3:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Reynolds Co. 2
23b. ADDRESS: Farmington Mo
23c. DATE SIGNED: 5-15-53

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: May 17 1953
24c. NAME OF CEMETERY OR CREMATORY: Doe Run Mo
24d. LOCATION (City, town, or county) (State): Doe Run Mo

DATE REC'D BY LOCAL REG.: May 16, 1953
REGISTRAR'S SIGNATURE: Esther Rudloff
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C.H. Cozean Farmington, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 1 1959

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 C H Cozean

Licensed Embalmer No. 4084

P. O. Address Farmington Me

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

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