

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023960

STATE FILE NUMBER

FILED JUL 11 1958

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1735

300

1-57

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|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST LOUIS</u>                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>CLAYTON</u>        |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>4051 BERKELEY</u>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br><u>ST LOUIS CO HOSPITAL</u> |  | Length of stay in lb<br><u>3 HRS</u>  | d. STREET ADDRESS (If outside, give location)<br><u>6V54 GRAHAM</u> |
|  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |

|   |                              |   |  |  |  |  |  |
|---|------------------------------|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>JEFFERSON John KROPF</u>                           |                              |   | 4. DATE OF DEATH<br>Month Day Year<br><u>6-28-58</u>   |  |  |  |  |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-1-1894</u>                    |  | 9. AGE (In years last birthday)<br><u>63</u> | 10. MONTHS UNDER 1 YEAR                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ELECTRICIAN</u> |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>UNEMPLOYED</u> | 11. BIRTHPLACE (City and state or country)<br><u>NY NEW YORK</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |  |

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 13a. FATHER'S NAME<br><u>LEOPOLD KROPF</u>   |  | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>UNK.</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>YES NWI</u> |  | 16. SOCIAL SECURITY NO.<br><u>49A-03-0203</u> |  | 17. INFORMANT<br><u>GILBERT KROPF</u> Address <u># SEMERSON CT CREVE COEUR MO</u> |  |  |  |

|  |  |  |  |  |  |                                  |  |
|--|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>4200</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |  |  |  |                                  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |  |  |  |  |  |                                  |  |

|   |  |   |  |                              |  |        |       |
|---|--|---|--|------------------------------|--|--------|-------|
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                       |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                            |  | 20f. CITY, TOWN, OR LOCATION |  | COUNTY | STATE |
| 21. I attended the deceased from <u>6-28-58</u> to <u>6-28-58</u> and last saw <sup>him</sup> alive on <u>6-28-1958</u> |  | Death occurred at <u>1:50 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated. |  |                              |  |        |       |

|   |  |   |  |                                    |  |
|---|--|---|--|------------------------------------|--|
| 22a. SIGNATURE (Degree or title)<br><u>Jane P. Page, M.D.</u> |  | 22b. ADDRESS<br><u>601 S. Brentwood Blvd.</u> |  | 22c. DATE SIGNED<br><u>6-29-58</u> |  |
|---|--|---|--|------------------------------------|--|

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> |  | 23b. DATE<br><u>7-2-58</u>             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>NATIONAL CEMETERY</u> |  | 23d. LOCATION (City, town, or county) (State)<br><u>JEFFERSON BARRACKS MO</u> |  |
| 24. FUNERAL DIRECTOR<br><u>W. Williams</u>                 |  | ADDRESS<br><u>9709 Lockwood Ov. MO</u> |  | 25. DATE RECD. BY LOCAL REG.<br><u>6-30-58</u>                 |  | 26. REGISTRAR'S SIGNATURE<br><u>Herbert R. Donker M.D.</u>                    |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....  
Signature of Student Embalmer

Signed *Earl G. Huberman* .....

Licensed Embalmer No. <sup>3501</sup>.....

P. O. Address *Orland, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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