

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020894

STATE FILE NUMBER

FILED JUN 29 1959

Registration District No. 115-116

Primary Registration District No. 3020

Registrar's No. 140

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Washington</i>		c. CITY OR TOWN <i>Washington</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Francis Hosp</i>		d. STREET ADDRESS <i>1105 E. Third St.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Louis H. KROPP</i>		4. DATE OF DEATH Month Day Year <i>June 30, 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 6, 1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cob Pipe Turner</i>		11. BIRTHPLACE (City and state or country) <i>Berger, Missouri, U. S. A.</i>	
13a. FATHER'S NAME <i>August Kropp</i>		14. NAME OF HUSBAND OR WIFE <i>Fatie R. Kropp</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown) (If yes, give year or dates of service) <i>No</i>		17. INFORMANT Address <i>Fatie R. Kropp, Washington, Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac decompensation</i> DUE TO (b) <i>Chr Arteriosclerotic Myocarditis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4221.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1</i>
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 Hour .Month, Day, Year a.m. p.m.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>April 6/59</i> to <i>6/30/59</i> and last saw ^{him} <i>6/19/59</i> Death occurred at <i>5:00 A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <i>6/20/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 22, 1959</i>		23b. DATE <i>6/22/59</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, Missouri</i>	
24. FUNERAL DIRECTOR <i>Wedberg & Co. Washington, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>6/23/59</i>	
26. REGISTRAR'S SIGNATURE <i>H. S. Sidman & J. R. Sidman</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NOV 30 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
Signature of Student Embalmer

Signed *Lester A. Witt*

Licensed Embalmer No. *3254*
P. O. Address *Washington, Md*

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.