SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2798 STATE FILE NUMBER 61-011538

FILED MAR 30 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 3224 TAFT
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3224 TAFT
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: LOUIS Middle: E. Last: SCHOPPER
4. DATE OF DEATH: Month: MAR. Day: 22 Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: AUG. 10 1876
9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HR: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED BARBER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: EUSTACIUS SCHOPPER
13b. MOTHER'S MAIDEN NAME: LOUISE JAMISON
14. NAME OF HUSBAND OR WIFE: TILLIE SCHOPPER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RAY SCHOPPER Address: 2700 CHIPPEWA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASHD
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): HCVD
DUE TO (c): Ca Prostate 420.0H
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Jan 1961 to March 22 and last saw her/him alive on March 22 61
Death occurred at 6:45 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): O'Keefe M.D.
22b. ADDRESS: 4075 S Grand
22c. DATE SIGNED: 3/23/61
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: MAR. 25 1961
23c. NAME OF CEMETERY OR CREMATORY: S.S. PETER & PAUL
23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo
24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: MAR 24 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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 Cooley Thompson Jr

Licensed Embalmer No. 4861

P. O. Address Clayton, 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.