MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6444 STATE FILE NUMBER 61-027027

FILED JUL 25 1961

AMENDED

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO.

DOCUMENT

AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2519 University St.
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): 2519 University St.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Frank Middle Leo Last Kopse

4. DATE OF DEATH: Month July Day 19th. Year 1961

5. SEX: M.
6. COLOR OR RACE: W.
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11/8/1898
9. AGE (last birthday): 62
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 Tile Setter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St.Louis,Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Joseph Kopse
13b. MOTHER'S MAIDEN NAME: Frances Kojaska
14. NAME OF HUSBAND OR WIFE

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: Mrs.Mamie Langsdorf, Address: 8714 Evans Lane

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): Cirrhosis of the liver
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 581.0
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 ____ to ____ and last saw her/him alive on ____
Death occurred at 1:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph M. Quinn Deputy Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 7-11-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 7-12-1961
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Memorial Gardens
23d. LOCATION (City, town, or county) (State): St Louis County

24. FUNERAL DIRECTOR: Arthur J. Donnelly
ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: JUL 11 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

JUL 27 1961

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4699

P. O. Address 3840 [illegible]

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.