

2696
S. No. 2
M-9-4-41
v. 5-17-39
I X29-184

19984

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED JUL 13 1942 791

Registration District No.

Primary Registration District No.

1003

006 5553

17
9 11

00
17
9

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Missouri**
(c) Name of hospital or institution:
St. Louis City Hospital
(d) Length of stay: In hospital or institution **7 Days**
In this community **45 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town..... **St. Louis**
(d) Street No. **3225 Montgomery St.**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Emil Schoop**

3. (b) If veteran, name war..... **Unknown**
3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, **Single**
6. (b) Name of husband or wife **Single** 6. (c) Age of husband or wife if alive **Single** years

7. Birth date of deceased **March 12, 1870**

8. AGE: Years **72** Months **3** Days **0**
If less than one day hr. min.

9. Birthplace **Switzerland**

10. Usual occupation **Laborer**

11. Industry or business **Unknown**

MOTHER FATHER { 12. Name **Isaac Schoop**
13. Birthplace **Switzerland**
14. Maiden name **Elizabeth Stockle**
15. Birthplace **Switzerland**

16. (a) Informant **Ann P. Morrison**
(b) Address **St. Louis City Hospital**

(c) Place: burial or cremation **Wentworth**

18. (a) Signature of funeral director **W. K. Kupper**
(b) Address **5502 Rutger**

19. (a) **JUN 29 1942** (Date received local registrar)
J. J. Breda (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **12**, year **1942** hour **11:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **June 6, 1942** to **June 12, 1942**; that I last saw him alive on **June 12, 1942**; and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic Heart Disease**

Due to **93**
Due to **93**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **Not done**
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury **0**

23. Signature **M. W. Davis** (M. D.)
Address **1515 Lafayette Ave.** Date signed **6/15/42**

(Licensed Embalmer's Statement on Reverse Side)

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.....
.....Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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