

FILED SEP 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28555
7317

406

BIRTH NO. _____ REG. DIST. NO. 348 PRIMARY REG. DIST. NO. 1005 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN St. Louis		a. STATE Mo.	b. COUNTY
c. LENGTH OF STAY (in this place) Life		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS 5202a Waterman Ave.	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) Henry			Aug 25, 1950
b. (Middle) Noel			
c. (Last) Poepping			
5. SEX M. <u>D</u>	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W.	8. DATE OF BIRTH Nov. 23, 1864
9. AGE (In years last birthday) 85	IF UNDER 1 YEAR 9 Months	IF UNDER 1 YEAR 2 Years	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Bernard Poepping	
13b. MOTHER'S MAIDEN NAME Jacqueline Primm		14. NAME OF HUSBAND OR WIFE Alice Poepping	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Noel Poepping, 5202a Waterman Ave.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Fr of the Left Hip; Arteriosclerosis</u> suppered when deceased fell to the floor in his room at 5202a Waterman Ave. any DUE TO (b) <u>330 pm</u> DUE TO (c) <u>Aug 17 1950 at about</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>fr of hip</u> Accident	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 17 50 330 p m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>E. 90.30</u>	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased life on _____, 19____, and that death occurred at <u>1:51 PM</u> from the causes and on the date stated above.			
23a. SIGNATURE <u>Reg. J. J. Donnelly</u> (Degree or title)		23b. ADDRESS <u>1300 Clark</u>	23c. DATE SIGNED <u>8/28/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 29, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
DATE REC'D BY LOCAL REG. <u>AUG 28 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Sander</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly, 3840 Lindell Blvd.</u>	

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

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
Student Embalmer

Signed _____

W. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.