

FILED FEB 11 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3615**
0990
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4153 W. Papin Street		d. STREET ADDRESS (If rural, give location) 18 4153 W. Papin St.	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Edgar	c. (Last) Pope	4. DATE OF DEATH (Month) (Day) (Year) Jan. 23, 1953
-------------------------------------	-------------------------	--------------------------	-----------------------	---------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 13, 1884	9. AGE (In years last birthday) 68	# MONTHS 6	YEAR 9	# MONTHS IN MO. Hours
--------------------	---------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	-------------------	---------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A
-----------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME John T. Pope	13b. MOTHER'S MAIDEN NAME Susan ?	14. NAME OF HUSBAND OR WIFE (Mrs) Beulah P. Pope
----------------------------------------	------------------------------------------	---------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME (Mrs) Beulah P. Pope	ADDRESS 4153 W. Papin
----------------------------------------------------------------------------------------------------------------------	-------------------------------------	---------------------------------------------------------------	------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Valvular Heart Disease		1 yr
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Renotism bronch rise to the above cause (a) stating the underlying cause last. DUE TO (c) Es		3 --
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diuretic			3 yr

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	----------------------------------------------------------------------------------

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NEITHER	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
---------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) X	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR X 727X
----------------------------------------------------------	--------------------------------------------------------------------------------------------------------	------------------------------------------------

22. I hereby certify that I attended the deceased from **Jan**, 19**53**, to **Jan**, 19**53**, that I last saw the deceased alive on **Jan 2, 1953**, and that death occurred at **8 P** m., from the causes and on the date stated above.

23a. SIGNATURE Samuel Stafford MD (Degree or title)	23b. ADDRESS St. Louis 6, Mo. 2605 A. Franklin Ave.	23c. DATE SIGNED Jan/26
------------------------------------------------------------	------------------------------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-28-1953	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis 20, Missouri
---------------------------------------------------------	----------------------------	----------------------------------------------------------------	-----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. JAN 28 1953	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE People's Und. Co.	ADDRESS 3100 Franklin Ave.
---------------------------------------------	-----------------------------------------------	-----------------------------------------------------------	-----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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. A. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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.