

FILED MAR 30 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

9674

BIRTH NO. _____ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 4234 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Iron		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission.) a. STATE Missouri b. COUNTY Reynolds	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ironton		c. LENGTH OF STAY (In this place) 8 days	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Mary's of the Ozarks		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) a. (First) Edmund	b. (Middle)	c. (Last) Popp	4. DATE OF DEATH (Month) (Day) (Year) March 14, 1953
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 30, 1874	9. AGE (In years last birthday) 78	10. UNDER 1 YEAR (Months) (Days) 8 14	11. UNDER 1 MIN. (Hours) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) restaurant operator- own	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Francis Popp	13b. MOTHER'S MAIDEN NAME Marie Schuler	14. NAME OF HUSBAND OR WIFE Katherine Popp
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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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Paul Stevens, Lesterville, MO
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs 7 yrs 7 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Labor Trauma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Neuropathia DUE TO (c) Hypertension		
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 490 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-7, 1953, to 3-14, 1953, that I last saw the deceased alive on 3-14, 1953, and that death occurred at 3 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John P. Jones, M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 3-14-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3-18-53	24c. NAME OF CEMETERY OR CREMATORY Sunset Park	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. 3-28-53	REGISTRAR'S SIGNATURE Mrs. Aris Jones	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS White Funeral Home, Ironton, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

0470
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MAR 30 1953

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

Fred J. White

Licensed Embalmer No. 3012

P. O. Address Proctor, 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 this body is not embalmed, fact should be so stated above.