

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34012

FILED OCT 15 1953

State File No.

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

Registrar's No. **9484**

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 town or township) St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		e. CITY OR TOWN St. Louis, 10	
		f. STREET ADDRESS (If rural, give location) 4406 San Francisco	
3. NAME OF DECEASED (Type or Print) a. (First) LILLIAN		b. (Middle)	
		c. (Last) SCHOPP	
		4. DATE (Month) (Day) (Year) OF DEATH October 1 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept-5 1885
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME August Vossmeier		13b. MOTHER'S MAIDEN NAME Louise Thusinger	
14. NAME OF HUSBAND OR WIFE Jacob Edward Schopp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. ?	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Viola Nienhaus		ADDRESS 4406 San Francisco	
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) Carcinoma of bladder ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 2-6-53		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Bladder	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		180X	
22. I hereby certify that I attended the deceased from <u>2-3-53</u> , 19 <u> </u> , to <u>10-1-53</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-1-53</u> , 19 <u> </u> , and that death occurred at <u> </u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>J. Carl Smith M.D.</i>		23b. ADDRESS 607 N. Grand, St. Louis 3, Mo.	
23c. DATE SIGNED 10-2-53			
24a. BURIAL CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct-5-1953	
24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. OCT 3 1953		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden F.H. Inc. 1936 St. Louis	

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

attached

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 None
Signature of Student Embalmer

Signed Felix J. Krupinski

Licensed Embalmer No. 34

P. O. Address St. Louis

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.