

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10767

STATE FILE NUMBER

FILED MAR 27 1957

318

1003

2312

Registration District No. Primary Registration District No. Registrar's No.

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN ST LOUIS, 3		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ENROUTE TO CITY HOSPITAL			Length of stay in 1b 20 79	d. STREET ADDRESS (If outside, give location) 4905 PENROSE			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J. MOHAPP				4. DATE OF DEATH Month Day Year MARCH 7, 1957			
5. SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 20, 1879		9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GARDNER			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) AUSTRIA +		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW MOHAPP				14. MOTHER'S MAIDEN NAME UNKNOWN KOEHLER			
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 Address MRS ANN KING 4905 PENROSE AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>							INTERVAL BETWEEN ONSET AND DEATH P.K.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Chronic Myocarditis with Degeneration 10 yrs</i>		DUE TO (c) <i>Coronary Thrombosis (Recovered) 10 yrs ago</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>Senility</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 420.1				
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>Part 10 years</i> and last saw <i>her</i> alive on <i>March 1, 57</i> Death occurred at <i>7:00 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>John A. Rogers M.D.</i>				22b. ADDRESS <i>6693 A ducar Blvd</i>		22c. DATE SIGNED <i>3/7/57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/11/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ST LOUIS MISSOURI</i>		
24. FUNERAL DIRECTOR ADDRESS <i>STROOT - CARROLL 4600 NATURAL BRIDGE AVE</i>				25. DATE RECD. BY LOCAL REG. <i>MAR 8 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

Rogers
608 Kingdon

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.....
Signature of Student Embalmer

Signed *M W Rueter*.....

Licensed Embalmer No. *4865*

P. O. Address *St Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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