

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1960

273

Primary Registration District No. 3051

Registrar's No. 97

-60-031528

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Perry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Perry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Perryville</b>		Length of stay in 1b <b>9 days</b>	c. CITY OR TOWN <b>Frohna</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Perry County Mem Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>C</b> Last <b>Popp</b>			4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-1907</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Perry County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Paul Popp</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Mueller</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Metz</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-01-3685</b>	17. INFORMANT <b>Mrs Florence Popp</b>	Address <b>Frohna, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b>		<b>24 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) <b>congestive heart failure</b>	<b>24 hrs</b>
	DUE TO (c) <b>multiple internal hemorrhages</b>	<b>2 weeks</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
<b>1) Hemorrhage on forehead</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>2) Swell about base of tooth after tooth extraction</b>		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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 **7/29/00** to **8/6/60** and last saw her alive on **8/6/00**  
Death occurred at **7:55 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Stanley H. Bayne M.D.</b>		22b. ADDRESS <b>Perryville Mo</b>	22c. DATE SIGNED <b>8/5/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-9-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Concordia Lutheran</b>	23d. LOCATION (City, town, or county) <b>Frohna Missouri</b>

24. FUNERAL DIRECTOR <b>Young &amp; Sons</b>	ADDRESS <b>Perryville Mo</b>	25. DATE RECD. BY LOCAL REG. <b>8-9-60</b>	26. REGISTRAR'S SIGNATURE <b>Josef Zellner</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Edward J. O'Connell*

Licensed Embalmer No. 2138

P. O. Address *Perquimans*

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.