N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9308

PLACE OF DEATH

County ~~Lupus~~ Moniteau

Township ~~Linn~~ or Village Lupus Mo or City ______ (No. ______ St.; ______ Ward)

Registration District No. 931 File No. ______

Primary Registration District No. 4177 Registered No. 8

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME John E. Lopp

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Male
COLOR OR RACE	white
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Married
DATE OF BIRTH	May 6, 1875 (Month) (Day) (Year)
AGE	38 yrs. 8 mos. 16 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work	Physicians
(b) General nature of industry, business, or establishment in which employed (or employer)	Practicing
BIRTHPLACE (City or town, State or foreign country)	Urbana Mo
PARENTS: NAME OF FATHER	Samuel Lopp
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Hermitage Mo
MAIDEN NAME OF MOTHER	Isabell Darby
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Hickory Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A. Abbott

(Address) 1102 S Kentucky Ave Sedalia Mo

Filed Mch 26, 191__ Vaughn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 22 nd, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ______, 191__, to ______, 191__, that I last saw h__ alive on ______, 191__, and that death occurred, on the date stated above, at ______ m.

The CAUSE OF DEATH* was as follows:

Verdict of Coroner's Jury Death from over dose of Bromidia taken accidentally

1777 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (Secondary) ______ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J P Burke Jr Coroner of Moniteau Co Mo M. D.

Mar 23, 1914 (Address) California Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ______

Former or usual residence ______

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pettigrew's Cemy	3/23, 1914
UNDERTAKER	ADDRESS
J L Manson	Overton Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County_____

Township _____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

City _____(NO._____, _____St.;_____Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1_____
(Month) (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day,_____hrs. or_____min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191___, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191___
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191___, to_____, 191___, that I last saw h_____ alive on_____, 191___, and that death occurred, on the date stated above, at_____m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds.

Contributory_____
(SECONDARY)

_____(Duration)_____yrs._____mos._____ds.

(Signed)_____ M. D.

_____, 191___ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death____yrs.____mos.____ds. In the State____yrs.____mos.____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191___
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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