

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

Do not use this space.

4577

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis Mo* (No. *St. Johns Hosp*)

File No.....

Registered No. *1261*

St. *1261* Ward)

2. FULL NAME *Edwing L Stampf*

(a) Residence. No. *2511 N. 12th St.* *26* Ward.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 2 - 1896*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

32

6

21

8. OCCUPATION OF DECEASED

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

Labour General

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

10. NAME OF FATHER

Louis Stampf

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Julia Sandford

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT

(Address)

Mary Stampf

2511 N. 12th St.

15.

FILED

26 1929

W. E. Stanley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 23 19 29*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 17* 19 *29*, to *Jan 23* 19 *29*, that I last saw him alive on *Jan 23* 19 *29*, and that death occurred, on the date stated above, at *10:15 AM* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hyper nephrosia of Rt. Kidney Malignant.

CONTRIBUTORY (SECONDARY)

Hyper nephrosia
duration 6 mos.

18. WHERE WAS DISEASE CONTRACTED

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Yes
Chas. Hugh Kellogg M. D.

*State the DISEASE CAUSING, DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

St. Johns North

Jan 26 19 29

20. UNDERTAKER

Woy Reidner 4nd 60 N. Market

ADDRESS *1417*

K. E.—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.

RECORD THIS IS A PERMANENT RECORD

