3590

Do not use this space.

~~3194~~ ~~3019~~

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

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~ File No. 1103

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis, Mo. (No. 519, E. Marceau St. ..... Ward)

2. FULL NAME Catherine Inkamp

(a) Residence. No. 519 E. Marceau. St., 1 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept.9.1852.

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
77	4	22	

8. OCCUPATION OF DECEASED 131

(a) Trade, profession, or particular kind of work At home 92c

(b) General nature of industry, business, or establishment in which employed (or employer) 102

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Pennsylvania
(STATE OR COUNTRY) Pennsylvania

PARENTS

10. NAME OF FATHER (Unknown) Franz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Pennsylvania

12. MAIDEN NAME OF MOTHER (unknown)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) (unknown)

14. INFORMANT Henry Inkamp
(Address) 519 E Marceau St

15. FILED FEB -3 1930 Max C Barker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan.31, 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 31, 1930 that I last saw her alive on Jan 30, 1930 and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

Chronic Myocarditis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Hypertension (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1 2 9 A

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) A W Peters, M. D.

Jan 31, 1930 (Address) 601 Missouri Bldg

*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
Park Lawn Cemetery	Feb.3 1930
20. UNDERTAKER Southern	ADDRESS 6320 S. Grand.

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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