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

Do not use this space.

24860

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. ..... Registered No. 7019

City St Louis (No. ..... St. ..... Ward)

2. FULL NAME Elisabeth Kampeter

(a) Residence. No. 4430 Bessie ave 7 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 2d 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
72	-	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework 93A 97
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Ferdinand Gossmann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Hy G. Kampeter
(Address) 4430 Bessie ave

15. FILED JUL 15 1930 19 Max C Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 - 15 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-14-30, 19..., to ..., 19..., that I last saw her alive on 7-14-30, 1930, and that death occurred, on the date stated above, at 7-15- 10 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
Cardiac Dilation
valvular disease
several yrs (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Old age
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Paul H. Chapman, M. D.
, 19 (Address) 3518 Dodier

*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: Calvary Cemetery — DATE OF BURIAL: July 17th 1930

20. UNDERTAKER: Edward Koch — ADDRESS: 3516 414 K

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.