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

Do not use this space.

2720

File No. .....
Registered No. .....

1. PLACE OF DEATH
County St Louis
Township St Ferdinand
City Baden (No. On No. 5 Kossuth St ..... St. ..... Ward)

Registration District No. 784
Primary Registration District No. 6030

2. FULL NAME Fred Lampe
(a) Residence. No. 1165 Howell St St Louis Mo 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.

FEB 23 1931

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 25 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	9	25	

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

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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) St Louis County Mo

PARENTS
10. NAME OF FATHER William Lampe
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Emma Lampe
(Address) 1165 Howell St St Louis Mo

15. FILED Jan 21st 1931 Dr Carl J. Kooch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1931 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10:30 A M m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Traumatism by tree falling upon body, shoving L. act of falling down tree was witnessed
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Fracture vertebrae
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? Baden Mo
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical exam
(Signed) John [illegible], M. D
Jan 20, 1931 (Address) Jennings St Louis County

*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
New Bethlehem Cemetery	Jan. 23 1931
20. UNDERTAKER	**ADDRESS**
Theo. H. Beiderwelden	1936 St Louis