

LEAD APR 7 1939

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

10744  
Do not use this space.

1. PLACE OF DEATH  
 (a) County FRANKLIN Registration District No. 295  
 (b) Township BOONE Primary Registration District No. 5415A  
 (c) City ..... (d) Street No. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MARTHA JANE STROTHKAMP  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOV. 2 1979

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
<u>59</u>	<u>4</u>	<u>-</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE

9. Industry or business in which work was done, as saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) 2/28/39 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) CUBA  
(STATE OR COUNTRY) MO.

FATHER  
 13. NAME JOHN ENLOE  
 14. BIRTHPLACE (CITY OR TOWN) MISSOURI  
(STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME FLOWMAN  
 16. BIRTHPLACE (CITY OR TOWN) TENN.  
(STATE OR COUNTRY)

17. INFORMANT JOHN STROTHKAMP  
(ADDRESS) SULLIVAN ROUTE

18. BURIAL, CREMATION, OR REMOVAL PLACE HOLY MARTYR JAPAN MO DATE 3/5 1939

19. FUNERAL DIRECTOR W. J. Mattenbacher  
(ADDRESS) Overmuller Mo.

20. FILED Mar 2 1939 Edgar W. Sullivan  
(City or Town) (County) (State)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 2 1939

22. I HEREBY CERTIFY, That I attended deceased from March 1 1939 to March 2 1939.  
 I last saw h. ER alive on March 2 1939. Death is said to have occurred on the date stated above, at 3:40 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Coronary stenosis Date of onset March

Other contributory causes of importance: 94 B -

Name of operation None Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. ....

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
 If so specify None  
 (Signed) R. C. Kitzell M. D.  
 (Address) Sullivan, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

NOTE: 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.

50M-7-20-37  
X12004

STATEMENT BY LICENSED EMBALMER

I, W.F. Gettenstracter Licensed Embalmer No. 1444

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed W.F. Gettenstracter

Licensed Embalmer No. 1444

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure of the above constitutes grounds for revocation of license.)**

CLERK OF DISTRICT  
M.B. - PAGE 1 X X

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

10744  
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 1104  
(b) Township Boone Primary Registration District No. 645A Registered No. 18  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MARtha Jane Stroth Kamp  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 2 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
59 4 -

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) 2/28/39 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cuba  
Mo

13. NAME John Enloe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Plowman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Japan

17. INFORMANT (ADDRESS) John Stroth Kamp  
Sullivan Route

18. BURIAL, CREMATION, OR REMOVAL PLACE Japan DATE 3/5 1939

19. FUNERAL DIRECTOR (ADDRESS) W F Kestemont  
Waverlyville Mo

20. FILED 1-15 1940 Chas C. Sweeney  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 2 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 1 1939 to Mar 2 1939

I last saw h. E.P. alive on Mar 2 1939 Death is said to have occurred on the day stated above, at 3:40 a.m.

The principal cause of death and related causes of importance were as follows:

coronary stenosis Mar 1

Other contributory causes of importance:

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_ If so, specify \_\_\_\_\_

(Signed) R.C. Kitchell, M. D.  
(Address) Sullivan Mo

If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

TEMPORARILY

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with