

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.

NOV 13 1939 791
Registration District No. **1008**

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 59 Yrs.
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Frederick Kammer 560
8. (b) If veteran, name war None
8. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, Widower
6. (b) Name of husband or wife Late Anna Kammer
6. (c) Age of husband or wife if alive 1st 1854 years (Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 0
If less than one day hr. _____ min. _____

9. Birthplace Kentucky
(City, town, or county) (State or foreign country)
10. Usual occupation Blacksmith retired
11. Industry or business Gerst Bros.

MOTHER FATHER
12. Name Nicholas Kammer
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Schlesinger
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. John Steinmetz
(b) Address 4401 Tholozan Ave.
17. (a) Burial (b) Date thereof 10-4th-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Peter & Paul Kriegshauser Mortuary
18. (a) Signature of funeral director 4228 So. Kingshighway
(b) Address

19. (a) OCT 3 1939 (b) [Signature]
(Date received local health officer)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4401 Tholozan Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1st
year 1939 hour 1:40 minute A.M. M.
21. I hereby certify that I attended the deceased from Sept. 25. 39
Sept 25, 1939 to Oct 1st, 1939;
that I last saw h. Mr. alive on October 1st, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Personal Apoplexy.
By perforation of aortic valve.
Due to _____
Due to _____
Other conditions (Include pregnancy within _____ months of death) _____
Major findings: Of operations _____
Of autopsy none.

Duration 3 day.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Julius E. [Signature] (M. D. or other) _____
Address 2603 Cherokee St Date signed Oct. 2 1939

2603 Olsen St.
2-4-7-8
R. K. Lohman

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Reinhold K. Lohman*

Licensed Embalmer No. *3395*

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.