

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

Do not use this space.

4561

**1. PLACE OF DEATH**

County 5069 Raymond  
 Township St. Louis  
 City St. Louis (No. 576)

Registration District No. 731  
 Primary Registration District No. 1003

File No. 1391  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward

**2. FULL NAME**

(a) Residence, No. O'Fallon, Mo. St. N.R. Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred - yrs. 4 mos. 11 ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**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 (OR) HUSBAND OF (OR) WIFE OF Conrad T. Kamp.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 6 - 1883

7. AGE YEARS 66 MONTHS 9 DAYS 5 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Chapin, Mo. (STATE OR COUNTRY) Union County, Mo.

13. NAME Christian Beckler

14. BIRTHPLACE (CITY OR TOWN) Hanover (STATE OR COUNTRY) Germany

15. MAIDEN NAME Catharine Bauer

16. BIRTHPLACE (CITY OR TOWN) Heinrichen (STATE OR COUNTRY) Germany

17. INFORMANT Mrs. Loma Callahan (ADDRESS) 5069 Raymond St. Louis

18. BURIAL, CREMATION, OR REMOVAL PLACE Old House Mo DATE Feb. 14, 1940

19. UNDERTAKER B. A. Keithly (ADDRESS) Orlean Mo

20. FILED FEB 12 1940 J. B. Bludick Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 11<sup>th</sup>, 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 1<sup>st</sup>, 1937, to Feb 11<sup>th</sup>, 1940

I last saw h. w. alive on Feb 11<sup>th</sup>, 1940. -Death is said to have occurred on the date stated above, at 11 a.m.

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

Metastatic carcinoma of breast Date of onset \_\_\_\_\_

Other contributory causes of importance: Chronic Myocarditis

Name of operation \_\_\_\_\_ 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 Warren B. Manton M. D.

(Signed) Warren B. Manton (Address) 607 - n Grand St. Louis, Mo.

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.

25

... of ...  
License # 822

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 45677  
Registrar's No. 1291

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Kamps

(b) If veteran, name war M (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-6-40 (b) J. J. Bradack  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11 year 40 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death  
Metastatic Carcinoma of breast - Primary seat left breast  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Chr. Myocarditis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy 50

Duration

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 H. J. Marston (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

