

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Cairo
(c) Name of hospital or institution Cairo Missouri
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 24 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME HENRY W. KAMP 510
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lena Kamp 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Feb. - 29 - 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 0
If less than one day hr. min.

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

10. Usual occupation Book Keeper

11. Industry or business _____

MOTHER FATHER
12. Name Fredrick Kamp
13. Birthplace Hanover Germany
(City, town, or county) (State or foreign country)
14. Maiden name Williamina Huddell
15. Birthplace Hanover Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. H.W. Kamp
(b) Address Cairo Missouri

17. (a) Burial (b) Date thereof Jan-31-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cassland Cemetery

18. (a) Signature of funeral director Snow Funeral Home
(b) Address Moberly Missouri

19. (a) Feb 3-40 (b) Dr J B Allen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Randolph
(c) City or town Cairo
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29th
year 1940 hour _____ minute 5:20 A.M.
21. I hereby certify that I attended the deceased from December 8th 1939, to January 29th, 1940
that I last saw him alive on January 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1-29-40
Due to Angina Pectoris 1-22-40
Due to Arterio sclerosis 12-8-39
Other conditions (Include pregnancy within 3 months of death) 4418

Major findings: Of operations _____
Of autopsy _____
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) no
(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? 658
(Specify type of place) (e) Means of injury _____
23. Signature Benj. S. Jolly D.D. (M.D. or other) _____
Address 2014 Reed Moberly Mo Date signed 1-30-40

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

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.

RECEIVED

District Health Officer No. 10

District File Number 4-40-817

Date Filed APR 11 1940

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, by.....

J. E. Barnes No 2414
working under my personal supervision.

Registered Apprentice No.....

Signed.....

R. M. Carter

Licensed Embalmer No.....

4117

P. O. Address.....

Moberly Mo.

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.