

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33888

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8585

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Anna Kamp

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 26 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 2 16 hr. min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name Louis E. Kamp
13. Birthplace St. Louis County Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Onleide
15. Birthplace St. Louis County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. A. Poggendorf
(b) Address Florissant, Mo. Rt. #1

17. (a) Burial (b) Date thereof 10/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Black Jack, Mo.

18. (a) Signature of funeral director Charles E. Brown

(b) Address 4911 Washington Bl.

19. (a) OCT 17 1940 (b) _____
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Rural NR
(If outside city or town limits, write "RURAL")
(d) Street No. Florissant Rt. #1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

20. DATE OF DEATH: Month Oct day 16
year 1940 hour 7:15 minute 4 M.

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

Immediate cause of death Asphyxiation due to asphyxiation when found on settling basin #4 and #5 of Chain of Rocks
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) on Oct 16 1940

Major findings: Of operations at 7:15 AM
Of autopsy suicide
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) suicide
(b) Date of occurrence 10/16/40
(c) Where did injury occur? St. Louis
(City or town) (County) (State)
(d) Did injury occur in a home, on a farm, in an industrial place, in a public place? Public Place

While at work? _____ (Specify type of place)
(e) Manner of injury _____

23. Signature Dr. Alfred Perry (M.D. or other)
Address Deputy Coroner Date signed 10/17

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.....

Licensed Embalmer No.

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.