

S. No. 2
 4-1-441
 5-17-39
 X26390

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 11985

REG APR 6 1942
 Registration District No. 184

Primary Registration District No. 117

Registrar's No. 742

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
427 Greeley Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 69 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
 (d) Street No. 427 Greeley
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Charles Kampschaefer
 (b) If veteran, name war Nil
 (c) Social Security No. 489-05-5808

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 1
 year 1942 hour 10 minute 20 P. M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Amelia Kampschaefer
 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased January 27 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 12 1942 to Apr 1st 1942
 that I last saw him alive on 3-29- 1942
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>2</u>	<u>4</u>	hr. min.

Immediate cause of death Cerebral hemorrhage secondary to Diabetes Mellitus (Pancreatic Hypate Cima)
 Due to _____
 Due to _____

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

Other conditions no
(Include pregnancy within 3 months of death)

10. Usual occupation Chauffeur
 11. Industry or business Department Store

Major findings:
 Of operations no
 Of autopsy no
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER {
 12. Name Gottlieb Kampschaefer
 13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Anna Feldt
 15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Amelia Kampschaefer
 (b) Address 427 Greeley Webster Groves
 17. (a) Burial (b) Date thereof April 4 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Peters Cemetery

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? _____

18. (a) Signature of funeral director Charles J. ...
 (b) Address 3934 N. 20th St.
 19. (a) APR - 2 1942 (b) C. E. Mc ...
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Gas A. Muller (M. D. or other) _____
 Address 2759 279th Date signed 4/2

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..... *Alfred J. Boedeker*
Licensed Embalmer No. *2663*
P. O. Address *5934 Alpha*

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, fact should be so stated above.