

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(c) Name of hospital or institution:
4460 Holly 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.....
years, months or days)

3. (a) PRINT FULL NAME Henry Willman Lampe
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 0 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna Lampe 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased April 27th 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 4 0 hr. min.

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

10. Usual occupation Retired Machinist

11. Industry or business.....

12. Name Henry Lampe

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

14. Maiden name Don't know

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

16. (a) Informant Anna Lampe

(b) Address 4460 Holly Ave.

17. (a) Burial (b) Date thereof 8-29-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cem.

18. (a) Signature of funeral director Provost Und. Co.

(b) Address 3710 N. Grand Blvd.

19. (a) AUG 28 1942 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County 12
(c) City or town St. Louis 99
(If outside city or town limits, write "RURAL")
(d) Street No. 4460 Holly Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 27th day
year 1942 hour 9.00 minute A. M.

21. I hereby certify that I attended the deceased from Jan 10
....., 1942, to Aug 27....., 1942
that I last saw him alive on Aug 20....., 1942
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Chronic Myocarditis ?

Due to.....
93

Due to.....
Arteriosclerosis ?

Other conditions Arteriosclerosis ?
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
93
Of autopsy.....

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)
(2) Means of injury 0

23. Signature Seth P. Smith (M. D. or other) 0

Address 4500 Clarence Date signed 8/28/42

S.P. Smith
4500 Francisco ave

88 0974

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

Signed A. A. Smithers
Licensed Embalmer No. 3916
P. O. Address 3710 N. Grand B

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.