S. No. 2
M—5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26531

Registration District No. FD SEP 3 1943 318 Primary Registration District No. 1003 Registrar's No. 7734

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

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: City Sanitarium 2-1-2-38-8-27-43
(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)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 12 ~~23~~

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. ~~1715 S. 10th St.~~ 13
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Camper

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race 0 White

6. (a) Single, widowed, married, divorced 1 Married

6. (b) Name of husband or wife Laura Camper

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Sept. 30, 1860 (Month) (Day) (Year)

8. AGE: 23 Years 82 Months 10 Days 27 If less than one day hr. min.

9. Birthplace Terre Haute Indiana 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Wm. Camper
13. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Don't Know
15. Birthplace Don't Know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura Camper
(b) Address 1715 S. 10th St.

17. (a) Removal RR. (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Terre Haute Indiana

18. (a) Signature of funeral director Weick Bros.
(b) Address 2201 S. Grand Bl.

19. (a) AUG 28 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27 year 1943 hour 5th minute 55th P.M.

21. I hereby certify that I attended the deceased from Aug 11, 1943, to Aug. 27, 1943; that I last saw him alive on Aug. 27, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia, Bronchial	2 days
Due to Senility and mid-thigh amputation - Lt.	1 wk. ago
Due to Gangrene of foot - rt. preceded amputation	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 98.2
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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. Wayne C. Anderson 0 (M. D. or other)
Address City Hospital - 1575 Lafayette Date signed 7-27-43

(Licensed Embalmer's Statement on Reverse Side)

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 [signature]

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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.