

FILED JAN 20 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 179

1. PLACE OF DEATH:

(a) County St. Louis Mo.
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4231 S. 37th St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 65 Years (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Rose Lampe

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Deceased Age of husband or wife if alive _____ years

7. Birth date of deceased April 14 1867
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 8 25 hr. _____ min.

9. Birthplace Germany (City, town, or county) (State or foreign country) 4

10. Usual occupation At Home

11. Industry or business _____

12. Name Wm. Bacher 4

13. Birthplace Germany (City, town, or county) (State or foreign country) 4

14. Maiden name Amalea Bacher

15. Birthplace Germany (City, town, or county) (State or foreign country) 4

16. (a) Informant Mollie Lampe

(b) Address 4231 S. 37th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-45
 (Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter & Paul Cem.

18. (a) Signature of funeral director Thompson & Parnell

(b) Address 3819 S. Grand Blvd

19. (a) JAN 8 1945 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4231 S. 37th St.
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 8th
 year 1945 hour 6:40 A.M. M.

21. I hereby certify that I attended the deceased from Jan. 2 1945 to Jan. 8 1945
 that I last saw her alive on Jan. 8 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Lobes Hypostatic Duration 4 days

Due to Ch. Myocarditis 2 yrs.

Due to Ch. Endocarditis Mitral 2 yrs.

Other conditions Nephritis Interstitial 2 yrs.
 (Include pregnancy within 3 months of death)

Major findings of operations none

Of autopsy none

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?

While at work? _____ (Specify type of place) (e) Means of injury no

23. Signature [Signature] (M. D. or other) MD
 Address 2767 Harris Ave Date signed 1-8-45

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..... *W. Wilkins*
Licensed Embalmer No. *3575*

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, fact should be so stated above.