

FILED JAN 31 1945  
318

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450

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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: Barnes Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6931 Lansdowne  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELIZABETH CELESTINE VAN CAMP

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 Married  
6. (b) Name of husband or wife William E. Van Camp 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 1, 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 2 12 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Halloran  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Eckman  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant W. E. Van Camp

(b) Address 6931 Lansdowne

17. (a) Burial (b) Date thereof 1/16/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Edith E. Ambruster

(b) Address 4234 Manchester

19. (a) JAN 16 1945 (b) J. B. Bredeek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13  
year 1945 hour 6 minute 40 A. M.

21. I hereby certify that I attended the deceased from Jan. 5, 1945, to Jan. 13, 1945;  
that I last saw her alive on Jan. 13, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis

Due to arteriosclerosis

Due to hypertensive vascular disease

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Examined

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) Means of injury \_\_\_\_\_

23. Signature James P. Gage (M. D. \_\_\_\_\_)  
Address Raynes Hospital Date signed 1/13/45

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

**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..... *Thomas Egnick*.....

Licensed Embalmer No. *1284*.....

P. O. Address..... *St. Louis Mo.*.....

**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.**