

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7557**
1855
Registrar's No.

FILED MAR 31 1946
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Christian Hospital
(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 Helen D. Holzkamp

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Frank W. Holzkamp

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased January 12, 1899
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>1</u>	<u>9</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Malvern Jones

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

14. Maiden name Louisa Weber

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

16. (a) Informant Miss. Marie Jones

(b) Address 5354 a Wells Ave.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Feb 25, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park Cemetery

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Avenue.

19. (a) FEB 25 1946 (Date received local registrar)

J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 5354 a Wells Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 21, 1946
year 2 hour 30 minute A M.

21. I hereby certify that I attended the deceased from Jan. 28
1946 to Feb. 21st 1946
that I last saw her alive on Feb. 21st, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death.	Duration
<u>Staphylococcus aureus of the liver capsule in the cavity of abdominal</u>	
Due to <u>arteries of abdominal cavity, duration</u>	
Due to <u>infection</u>	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy	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) (e) Means of injury _____

23. Signature Rose Minnie Rose M.D. (M. D. or other)

Address 5301 A Easton Ave Date signed 2/23

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed *John Gonoski*

Licensed Embalmer No. *3398*

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.