

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5973**

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:
St Johns Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 hrs**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **Elizabeth Adele Haverkamp**

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 **Single**

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

7. Birth date of deceased **Oct 29 1904**
(Month) (Day) (Year)

8. AGE: Years **43** Months **8** Days **3** If less than one day hr. min.

9. Birthplace **St Louis Mo 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business.....

12. Name **Bernard Haverkamp**

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

14. Maiden name **Katherine Ruerer**

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

16. (a) Informant **Katherine Haverkamp**

(b) Address **4387 Donavan**

17. (a) **Burial** (b) Date thereof **July 7-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **SS Peter Paul Cem**

18. (a) Signature of funeral director **Rowland Mortuary Service**

(b) Address **4104 Manchester Ave.**

19. (a) **JUL 6 1948** (b) **J. F. Bredeck**
(Date received local health officer) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St Louis** **17**
(If outside city or town limits, write "RURAL") **9**
(d) Street No. **4387 Donavan** **18**
(If rural, give location)
(e) Citizen or foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7** year **1948** hour **7:30** minute **P.M.**

21. I hereby certify that I attended the deceased from **June 30**, 19**48**, to **July 7**, 19**48** that I last saw her alive on **July 7**, 19**48** and that death occurred on the date and hour stated above.

Immediate cause of death **Subarachnoid hemorrhage** **10 hrs?**
Due to **Lymphatic leukemia**

Due to.....
Other conditions (Include pregnancy within 3 months of death) **7 H**

Major findings: Of operations..... 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?

23. Signature **William A. Turner** (Specify type of place) (c) Means of injury **mb**
Address **St Johns Hosp.** Date signed **7-2-48**

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

MOTHER FATHER

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 Howard R. Pauland

Licensed Embalmer No. 3114

P. O. Address OT Lewis Ma

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.