

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26563

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3620</u>		Registrar's No. <u>126</u>	
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>			c. LENGTH OF STAY (in this place) <u>4 months</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rosebud</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Josephine</u> b. (Middle) <u>Caroline</u> c. (Last) <u>Kampen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 10, 1949</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 24, 1877</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Days <u>6</u>	IF UNDER 24 HRS. Min. <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>**</u>	11. BIRTHPLACE (State or foreign country) <u>Lebanon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Henry Reimer</u>		13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Leuweker</u>		14. NAME OF HUSBAND OR WIFE <u>August Kampen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If yes, give war or dates of service) <u>**</u>	16. SOCIAL SECURITY NO. <u>**</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Otto Kampen</u> ADDRESS <u>Union, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of transverse colon</u></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u></p>						INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>
19a. DATE OF OPERATION <u>1-12-48</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of transverse colon with extensive metastases</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Nov., 1948</u> , to <u>Dec-10, 1949</u> , that I last saw the deceased alive on <u>8-9, 1949</u> , and that death occurred at <u>2:30 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Paul A. Branner, M.D.</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>Owensville, Mo.</u>			23c. DATE SIGNED <u>8-11-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rosebud, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Aug. 11, 1949</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>99</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Milford H. H. White</u> ADDRESS <u>OWENSVILLE</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-4836
6
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District File Number _____
District Health Officer No. 9,
AUG 15 1949
RECEIVED

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, ~~XXXX~~ _____

Student Embalmer No. _____

working under my personal supervision.

Signed Merford H. H. Winter

Signed _____
Student Embalmer

Licensed Embalmer No. 3838

P. O. Address Owensville, 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.