

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37848

State File No. _____

FILED DEC 14 1949

56

BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 5666 Registrar's No. 22

| | | | |
|--|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Lewis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Ill</u> b. COUNTY <u>Adams</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-UNION</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>QUINCY</u> | |
| c. LENGTH OF STAY (In this place) <u>1</u> | | d. STREET ADDRESS (If rural, give location) <u>0</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Funkan Bush Home</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Sophia</u> | | b. (Middle) <u>Nie Kamp</u> | |
| c. (Last) <u>Nie Kamp</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 5 1949</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) <u>99</u> | IF UNDER 1 YEAR Months <u>2</u> Days <u>20</u> | IF UNDER 1 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13a. FATHER'S NAME <u>Henry Rosenketter</u> | | 13b. MOTHER'S MAIDEN NAME <u>Fredricka Daat</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>John L. Nie Kamp</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>X</u> | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>MRS ARCH FUNKENBUSH</u> | | ADDRESS <u>Maywood 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MYOCARDITIS (CHRONIC)</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>49.7.2</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>!</u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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>MAY 24</u> , 1949, to <u>DEC 5</u> , 1949, that I last saw the deceased alive on <u>DEC 1</u> , 1949, and that death occurred at _____ m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE <u>W F ELLen MD</u> (Degree or title) | | 23b. ADDRESS <u>La Grange Mo</u> | |
| 23c. DATE SIGNED <u>12/5/49</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 24b. DATE <u>DEC 5 1949</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT Cem.</u> | | 24d. LOCATION (City, town, or county) (State) <u>Quincy Ill</u> | |
| DATE REC'D BY LOCAL REG. <u>12-10-49</u> | | REGISTRAR'S SIGNATURE <u>O. St. Jennings MD</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul A. Vaughn</u> | | ADDRESS <u>La Grange Mo</u> | |

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

RECEIVED DEC 12 1948
District Health Officer No
District File Number 12-49-2
Date Filed

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Paul A. Vaughan

Signed _____
Student Embalmer

Licensed Embalmer No. *4509*

P. O. Address *La Grange, Ill.*

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.