

FILED NOV 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39220

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 8821

BIRTH NO.

REG. DIST. NO.

I. PLACE OF DEATH

a. COUNTY

SAINT LOUIS

b. CITY (If outside corporate limits, write RURAL and give township)

OR TOWN

c. LENGTH OF STAY (In this place)
Wks

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Deaconess Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

MISSOURI

b. COUNTY

SAINT LOUIS

c. CITY (If outside corporate limits, write RURAL and give township)

TOWN

WEBSTER GROVES, MO. 4577

d. STREET ADDRESS (If rural, give location)

874 Greeley

3. NAME OF DECEASED
(Type or Print)

a. (First)

Emma

b. (Middle)

Herkstroeter

c. (Last)

Kamp

4. DATE OF DEATH (Month) (Day) (Year)
Oct 3 1951

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

1/2/77

9. AGE (In years) (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

74

9

1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, Mo. D

12. CITIZEN OF WHAT COUNTRY?

USA

13a. FATHER'S NAME

Casper H. Herkstroeter

13b. MOTHER'S MAIDEN NAME

Wilhemina Gast

14. NAME OF HUSBAND OR WIFE

Edward A. Kamp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT'S SIGNATURE OR NAME ADDRESS

E. A. Kamp, 874 Greeley, W. G. Mo.

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES

Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

Carcinoma, Abdominal

Carcinoma of Ovary Rt

1 yr

no

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

Cn Rt Ovary

20. AUTOPSY?

YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office (etc., etc.))

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

175X

22. I hereby certify that I attended the deceased from Aug 23, 1951, to 10/3/51, 1951, that I last saw the deceased alive on 10/3/51, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)

Henry D. Meyer

M. D.

23b. ADDRESS 23c. DATE SIGNED

508 No. Grand

10/4/51

24a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24b. DATE

10/8/51

24c. NAME OF CEMETERY OR CREMATORY

Lake Charles Park

24d. LOCATION (City, town, or county) (State)

Saint Louis Mo.

DATE REC'D BY LOCAL REG.

9/15 1951

REGISTRAR'S SIGNATURE

J. Earl Smith M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

Ambruster Mortuary, 6633 Clayton Road

18-7907

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.

Student Embalmer No.....

Signed.....

John Ketter

Signed.....

Student Embalmer

Licensed Embalmer No. 3880

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.