

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13579

3013

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS MO</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before (d) institution). a. STATE <u>Illinois</u> b. COUNTY <u>CLINTON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS MO</u>		c. LENGTH OF STAY (in this place) <u>2 Mos.</u>		c. CITY OR TOWN <u>Carlyle</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CHILDREN'S</u>				e. STREET ADDRESS (If rural, give location) <u>812<sup>0</sup> 8</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>THERESA</u> b. (Middle) <u>MARIE</u> c. (Last) <u>HOLLENKAMP</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4-2-54</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>6-9-52</u>	
9. AGE (In years last birthday) <u>1 1/2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>VINCENT H. HOLLENKAMP</u>		13b. MOTHER'S MAIDEN NAME <u>ANN NOTHAUS</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. EGAN 500 So. Kings Highway</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>Chronic glomerulonephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> ANTECEDENT CAUSES Morbid 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.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) <u>592X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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>1-30</u> , 19 <u>54</u> , to <u>4-2</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>54</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wes G. Klingberg MD.</u>				23b. ADDRESS <u>500 S. Kings Highway</u>		23c. DATE SIGNED <u>4-2-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-2-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		24d. LOCATION (City, town, or county) (State) <u>Carlyle, Illinois,</u>	
DATE REC'D BY LOCAL REG. <u>APR 8 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe 4700 Washington.</u>			

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

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..

Student.....  
Signature of Student Embalmer

Signed *Robert M Murray*.....

Licensed Embalmer No. *3749*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.