

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9397</b>			
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>1 yr</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4318a Warne</b>				e. STREET ADDRESS (If rural, give location) <b>9 4318 Warne</b> <b>2099</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ernst</b>		b. (Middle) <b>John</b>		c. (Last) <b>Kamphoefner</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 14 1954</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>May 4 1879</b>			
9. AGE (In years last birthday) <b>75</b>		10. MONTHS <b>7</b>		11. DAYS <b>5</b>		12. HOURS <b>11</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Foundry</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>New Melle Mo</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13a. FATHER'S NAME <b>John F Kamphoefner</b>		13b. MOTHER'S MAIDEN NAME <b>Wilhelmina Weinrich</b>		14. NAME OF HUSBAND OR WIFE <b>Lydia Kamphoefner</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Vernon Kamphoefner</b>				ADDRESS <b>St Charles Mo</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Broncho pneumonia</b> ANTECEDENT CAUSES <b>Arterio Sclerotic Heart Dis</b> 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.				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>5 yrs.</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						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. HOW DID INJURY OCCUR? <b>4200</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <b>Sept. 2, 1954</b> , to <b>Oct 14, 1954</b> , that I last saw the deceased alive on <b>Oct 13, 1954</b> , and that death occurred at <b>7 A</b> m., from the causes and on the date stated above.					
23a. SIGNATURE (Doctor or title) <b>H. J. Houck M.D.</b>				23b. ADDRESS <b>8702 Riverview Blvd</b>		23c. DATE SIGNED <b>10-16-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct. 17 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Charles Mo.</b>			
DATE REC'D BY LOCAL REG. <b>OCT 18 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur C. Bane M.D.</b>		ADDRESS <b>St. Charles Mo.</b>			

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

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**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 *Francis M. Bills*.....

Licensed Embalmer No. *437*.....

P. O. Address *St. Charles*.....

**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.