

FILED SEP 19 1956

STANDARD CERTIFICATE OF DEATH

29184

State File No. ....

BIRTH NO. REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 342

1. PLACE OF DEATH a. COUNTY <b>Cape Girardea</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Gir.</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Cape Girardeau</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Jackson</b>	
c. LENGTH OF STAY (In this place) <b>36 hrs.</b>		d. STREET ADDRESS (If rural, give location) <b>506 North High</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Francis Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Caroline</b> b. (Middle) <b>,Kamp</b> c. (Last) <b>Huter</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 7 1955</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED,* WIDOWED, DIVORCED (Specify) <b>Widow</b>	
8. DATE OF BIRTH <b>June 25, 1877</b>			9. AGE (In years) (Month) (Day) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>
11. BIRTHPLACE (State or foreign country) <b>Scopus, Missouri</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		

13a. FATHER'S NAME <b>August Kamp</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Scrock</b>		14. NAME OF HUSBAND OR WIFE <b>August Huter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Link</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Albert Nagel Jackson, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Arteriosclerosis</b>			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Acute cholecystitis</b>		<b>3 days</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4/6 X</b>		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

I hereby certify that I attended the deceased from **Sept 6, 1954**, to **Sept 7, 1956**, that I last saw the deceased alive on **Sept 6, 1956**, and that death occurred at **5:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. N. Jaeger MD</b> (Degree or title)		23b. ADDRESS <b>Jackson, Mo.</b>		23c. DATE SIGNED <b>Sept 8, 1956</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 10, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Russell-Heights</b>	
		24d. LOCATION (City, town, or county) (State) <b>Jackson Mo.</b>			

DATE REC'D BY LOCAL REG. <b>9-12-55</b>		REGISTRAR'S SIGNATURE <b>C. C. Summers</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>St. Crae Craft Jackson, Mo.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 16 1955

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 .....  
Student Embalmer

Signed \_\_\_\_\_

*Gene C. Cooney*  
4-3127

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*Meriden, 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.