

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37068

State File No.

300
48

FILED NOV 23 1955

4711

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>15 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>		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 <u>Linmont Nursing Home</u>					
80 • STREET ADDRESS (If rural, give location) <u>5542 Park</u> 38050					

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>AUGUSTE</u>	b. (Middle) <u>A</u>	c. (Last) <u>VON KAMPEN</u>	(Month) <u>11</u>	(Day) <u>2</u>	(Year) <u>1955</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, 2. WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 17th 1873</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u> <u>4</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>(Unknown) Lindeman</u>	13b. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>John M. Von Kampen</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Walter Von Kampen</u>	ADDRESS <u>218 Brush Creek</u>
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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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho Pneumonia</u>		<u>4 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis Cong</u> 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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Oct 12, 1945, to Nov. 2, 1955, that I last saw the deceased alive on Nov. 1, 1955, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edward A. Samuelson, M.D.</u> (Degree or title) °	23b. ADDRESS <u>2603 831 K.C. Mo.</u>	23c. DATE SIGNED <u>Nov. 3-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11-3-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sioux Falls, S. D.</u>
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DATE REC'D BY LOCAL REG. <u>11-4-55</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Melody-McGilley-Eylar</u>	ADDRESS <u>1800 E. Linwood</u>
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(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 *James E. Kachler*.....
Licensed Embalmer No. *452*

P. O. Address *K. C., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.