

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003730  
STATE FILE NUMBER

8  
FILED JAN 19 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 117

300  
1-57

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>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		c. CITY OR TOWN <b>Lemay</b> <b>4870</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>County Hospital</b>		d. STREET ADDRESS <b>757 Lemay Ferry Road</b> (If outside, give location)	
Length of stay in lb <b>2 mos.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katie (KATE) Kammerer</b>			4. DATE OF DEATH Month Day Year <b>1-8-1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1894</b>
9. AGE (In years (least birthday)) <b>64</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Hungary</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Fred Gender</b>	
13b. MOTHER'S MAIDEN NAME <b>Anna Behrenz</b>		14. NAME OF HUSBAND OR WIFE <b>John Kammerer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>490-05-1547</b>	
17. INFORMANT <b>Max Kammerer</b>		Address <b>10563 Kamping Lane (23)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Post-OP Wound Infection</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>Diabetes mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>Clayton</b>		COUNTY STATE	
21. I attended the deceased from <b>11-4-1958</b> to <b>1-8-1959</b> and last saw her alive on <b>1-8-1959</b> Death occurred at <b>5:20p</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John E. Oakley, M.D.</b> (Deponent title)		22b. ADDRESS <b>601 S. Brentwood, Clayton</b>	
22c. DATE SIGNED <b>1/10/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-12-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis 16, Missouri</b>	
24. FUNERAL DIRECTOR <b>Hendler Und. Co.</b>		ADDRESS <b>7420 Michigan (11)</b>	
25. DATE RECD. BY LOCAL REG. <b>1-12-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no trace. All diseases in Part I must be causally related.

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 *W. A. Peterson* .....

Licensed Embalmer No. *3767* .....

P. O. Address *7420 Mish* .....

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.