URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-030575

STATE FILE NUMBER

FILED VS AUG 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2-7391

NDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,

Length of stay in 1b

c. CITY OR TOWN ST LOUIS,

Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2154 E. WARNE AVE

Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 2154 E. WARNE AVE

Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First CLEMENS Middle LAMPE Last

4. DATE OF DEATH Month AUG, Day 7, Year 1959

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 6/16/1882

9. AGE (last birthday) 77

IF UNDER 1 YEAR Months Days

IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED POLICE OFFICER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME BERNARD LAMPE

13b. MOTHER'S MAIDEN NAME HENRIETTA STEINRICKER

14. NAME OF HUSBAND OR WIFE FRANCES LAMPE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT FRANCES LAMPE Address 2154 E. WARNE AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Hypert. Arterio Sclerotic C.V. Dis. — INTERVAL BETWEEN ONSET AND DEATH: 8 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 443

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) —

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year —

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 19 1957 to Aug 7 59 and last saw her/him alive on Aug 7-59

Death occurred at 1:15 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Albert J. Hagel M.D. (Degree or title)

22b. ADDRESS 2139 No Grand Blvd

22c. DATE SIGNED Aug 8-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 8/10/59

23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY

23d. LOCATION (City, town, or county) ST LOUIS MISSOURI (State)

24. FUNERAL DIRECTOR STROOT — CARROLL ADDRESS 4600 NATURAL BRIDGE

25. DATE RECD. BY LOCAL REG. AUG 10 '59

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed M W Ruter

Signature of Student Embalmer

Licensed Embalmer No. 4865

P. O. Address St Louis M

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