

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-011984

ED APR 10 1961
AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 816

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Florissant		Length of stay in lb 40 Yrs.	c. CITY OR TOWN Florissant Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route # 2 Box 438		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route # 2 Box 438 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Henry Middle Fred Last Kamp			4. DATE OF DEATH Month March Day 24 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-12-80
9. AGE (last birthday) 80		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) Ranch Owner		10b. KIND OF BUSINESS OR INDUSTRY Ranch	11. BIRTHPLACE (City and state or country) Florissant, Mo.
12. CITIZEN OF WHAT COUNTRY U. S.		13a. FATHER'S NAME Herman Kamp	
13b. MOTHER'S MAIDEN NAME Anna Benne		14. NAME OF HUSBAND OR WIFE Nora E. Kamp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT Nora E. Kamp, Florissant, Mo. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 min 5 yrs
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. _____ Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	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 Jan 1957 to 3/24/61 and last saw her him alive on 3/23/61 Death occurred at 9:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>M D Shuman M D</i> (Degree or title)		22b. ADDRESS Ferguson Mo	22c. DATE SIGNED 3/24/61 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-27-61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) Normandy, Mo.
24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 3-24-61	26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>

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 Reinhold K. Lohmann

Licensed Embalmer No. 3345

P. O. Address Harris 3522

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.