

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036578

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 138 Primary Registration District No. 2000 Registrar's No. 1019A

FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before a. STATE <u>Mo</u> b. COUNTY <u>WEBSTER</u> )	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield</u>		Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>MARSHFIELD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>520 S Pike</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>KATH</u> First Middle Last	<u>Lewis Kamerer</u>	4. DATE OF DEATH <u>OCT 23 1961</u> Month Day Year
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-1889</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Crane operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>KARL KAMERER</u>	13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Ebel</u>	14. NAME OF HUSBAND OR WIFE <u>Aghes</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Aghes Kamerer</u> Address <u>MARSHFIELD MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from ruptured aortic.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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
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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.)
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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 <u>Springfield Missouri</u>	COUNTY <u>WEBSTER</u>	STATE <u>MO.</u>
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21. I attended the deceased from <u>10-22-61</u> to <u>10-23-61</u> and last saw <u>him</u> alive on <u>10-23-61</u> Death occurred at <u>9:40 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Springfield Missouri</u>	22c. DATE SIGNED <u>10-27-61</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-23-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Welch</u>	23d. LOCATION (City, town, or county) <u>WEBSTER Co. MO.</u>
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24. FUNERAL DIRECTOR <u>Barber Edwards</u> ADDRESS <u>MARSHFIELD</u>	25. DATE RECD. BY LOCAL REG. <u>10-30-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

NOV 6 1961

*Dr. Fitch*

**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 *L. Stephen Gorman*

Licensed Embalmer No. 3177

P. O. Address *Springfield 2*

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.