

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042580

Registration District No. 318, Primary Registration District No. 1003, Registrar's No. 10426 STATE FILE NUMBER

AMENDED
DATE PREPARED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
ITEM NO.
BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4643 TENNESSEE Inside Limits Yes No

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

c. CITY OR TOWN SHREWSBURY Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 445 WILSHUSEN Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE G. KAMPS

4. DATE OF DEATH Month Day Year 11-7-1961

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 12-24-1869 9. AGE (last birthday) 91

10a. USUAL OCCUPATION (Give kind of work done during month of working life, even if retired) AT HOME 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (City and state or country) GERMANY 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. MOTHER'S NAME Ed. HOFFMAN 13b. MOTHER'S MAIDEN NAME NOT KNOWN 14. NAME OF HUSBAND OR WIFE DECEASED.

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

16. SOCIAL SECURITY NO. NONE 17. INFORMANT Address Geo Gramlich 4643 Tennessee

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Transition
DUE TO (b) arterio-sclerotic CVR 2 weeks 5 yrs
DUE TO (c) 442x
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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 1-10-61 to 11-7-61 and last saw her alive on 11-5-61
Death occurred at 6:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C A Hester MD 22b. ADDRESS 5600 S Compton 22c. DATE SIGNED 11-17-61

23. NAME OF CEMETERY OR CREMATORY Resurrection Cem. 23d. LOCATION (City, town, or county) (State) St. Ann. Co. Mo.

24. FUNERAL DIRECTOR ADDRESS St. Marysmehl 3819 So Grand 25. DATE RECD. BY LOCAL REG. 11-9-1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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

George J. Embalmer

Licensed Embalmer No. 4611

P. O. Address St Louis 18 Mo

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.