

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019429

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered District No. 172 Primary Registration District No. 3034 Registrar's No. 46  
**FILED JUN 13 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Lafayette</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>701 W 29<sup>th</sup> HIGGINSVILLE</u> Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>LAFFAYETTE MISSOURI</u> b. COUNTY c. CITY OR TOWN <u>HIGGINSVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>701 W 29<sup>th</sup></u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Anna Marie Kampschmidt</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>6 - 8 62</u>				
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>9-3-1879</u>		<b>9. AGE (last birthday)</b> <u>82</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Gerald MO. U.S.A.</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>FERDINAND HOEPPNER</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>WILHELMINE OVERKAMPER</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>J.E. KAMPSCHMIDT</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>			
<b>17. INFORMANT</b> <u>J.E. KAMPSCHMIDT HIGGINSVILLE MO</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelogenous Leukemia</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 INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		<b>21. I attended the deceased from</b> <u>after death</u> to <u>on 6-8-62</u> and last saw her alive on <u>never</u> Death occurred at <u>5:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>W.M. Martin MD Coroner</u>			<b>22b. ADDRESS</b> <u>Odessa Mo</u>				
<b>22c. DATE SIGNED</b> <u>6-11-62</u>		<b>23a. BURIAL, CREMATION, (Specify)</b> <b>23b. DATE</b> <b>23c. NAME OF CEMETERY</b> <b>23d. LOCATION</b> (City, town, or county) (State) <u>BURIAL 6-11-1962 HIGGINSVILLE CITY HIGGINSVILLE MO</u>					
<b>24. FUNERAL DIRECTOR</b> <u>WIEGERS-RIEKHOF HIGGINSVILLE MO</u>		<b>25. DATE RECD. BY LOCAL REG.</b>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Katie Jordan Jordan</u>			

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Roy F. Wiegman*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.