MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 2754
Registered No. 189

1. PLACE OF DEATH

County
Township
City St Louis (No. 5423 Rosa AVE St. Ward)

Registration District No. 791
Primary Registration District No. 1003

2. FULL NAME August Kamber

(a) Residence. No. 5423 Rosa ave St., 2 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mrs Katharine Kamber

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12 1867

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
62	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery store
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Switzerland

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Switzerland
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Switzerland

14. INFORMANT Mrs. Katharine Kamber
(Address) 5423 Rosa ave

15. FILED JAN -6 1930 Max C. Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 4 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to death, 1930 that I last saw him alive on January 4, 1930 and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93c
97.
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Generalized Arteriosclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Gustav A. Eckmann M.D.
1/6 1930 (Address) 1722 South Jefferson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL S.S. Peter & Paul — DATE OF BURIAL 1-7 1930

20. UNDERTAKER Kriegshauser Funeral Co. — ADDRESS 4228 S. Kingshighway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

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DECLASSIFIED