

No. 300  
10-47  
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FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
#91404  
FILED NOV 12 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

34591  
State File No. \_\_\_\_\_  
Registrar's No. 9642

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 1/2 Days  
(Specify whether Memorial 9)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2005 E. Geno Ave  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME KATHERINE RAMSPOTT  
3. (b) If veteran, name war None 3. (c) Social Security No. None  
4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Anthony 6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased June 26 1885  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 4th  
year 1948 hour 6 minute 25 M.  
21. I hereby certify that I attended the deceased from Nov 2 1948 to Nov. 4th, 19 48  
that I last saw her alive on Nov. 4th, 19 48  
and that death occurred on the date and hour stated above

Immediate cause of death Myocardial infarction Duration \_\_\_\_\_  
Due to Arteriosclerotic changes + thrombosis.  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Thrombosis of anterior + lateral coronary arteries  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death would be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work \_\_\_\_\_ (Specify name of place)  
23. Signature John B. Lasser Date signed 11/2/48  
Address 1515 Lafayette

8. AGE: Years 63 Months 4 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_  
12. Name Louis H. Klenke  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Penn  
(City, town, or county) (State or foreign country)  
16. (a) Informant Anthony Ramsrott  
(b) Address 2005 E. Geno Ave  
17. (a) Via Motor (b) Date thereof 11-8-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Nashville, Illinois  
18. (a) Signature of funeral director Math. Hermann & Son, Inc.  
(b) Address 2161 E. Fair Ave  
19. (a) Nov 5 1948 (b) J. B. Lasser  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *William G. Burkholder*

Licensed Embalmer No. *2110*

P. O. Address *St. Louis, 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 this body is not embalmed, fact should be so stated above.**