

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

4707

1. PLACE OF DEATH

County Haskell
 Township Haskell
 City Brandsville (No. _____)

Registration District No. 384
 Primary Registration District No. 3535

File No. 13
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Robert Lester Kemp
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wife

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 1 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) West Plains
 (STATE OR COUNTRY) MO.

PARENTS

10. NAME OF FATHER Frank Lester

11. BIRTHPLACE OF FATHER (CITY OR TOWN) MO.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah J. Whitney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) MO.
 (STATE OR COUNTRY)

14. INFORMANT Frank Lester
 (Address) Brandsville, Mo.

15. FILED 2-27-23 O.P.A. Heintz
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 22 1923

I HEREBY CERTIFY, That I attended deceased from Jan 23 1923, to Feb 22 1923, that I last saw him alive on Feb 22 1923, and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Graus disease
tuberc
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) _____
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. J. Maddox, M. D.
 19 (Address) Brandsville Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Union Hill DATE OF BURIAL Feb 24 1923

20. UNDERTAKER McFarland and Co. ADDRESS West Plains

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"; *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide. Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificate will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Feb. 1923

1 PLACE OF DEATH

County Howell State MISSOURI. 384 Registered No. _____
 Township Howell or Village 5535 or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Phosphor Laster Kemp

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____		
6 DATE OF BIRTH (month, day, and year) <u>Jan 20 - 1880</u>		
7 AGE Years _____ Months _____ Day _____	If LESS than 1 day _____ hrs. or _____ min.	
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

6 DATE OF DEATH (month, day, and year) Feb 22 1923

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

9 BIRTHPLACE (city or town) _____ (State or country) _____
10 NAME OF FATHER _____
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____
12 MAIDEN NAME OF MOTHER _____
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

CONTRIBUTORY (SECONDARY) _____ (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) _____, M. D.
 _____, 19 (Address) _____

14 Informant _____ (Address) _____

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

15 Filed 2-27, 1923 O.P. Heinrich REGISTRAR

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

This form is to be filled out by the physician or other person who attended the deceased. It should be filled out as soon as possible after death. See instructions on back of certificate.

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