

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

Do not use this space.

20919

1. PLACE OF DEATH

County Jackson
Township Kaw.
City Kansas City (No. 416 1/2 E. 15th St.)

Registration District No.

Primary Registration District No.

File No.
Registered No. 2801
St. Ward

2. FULL NAME

Laura Kemper
(a) Residence. No. 823 E. 14th St., 2 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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 3 - 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 | 11 | 25

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Wilks Pugh

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Luelle Bowen
(Address) 505 W. 18th

15. FILED 6-30-28 M M Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 1928

17. I HEREBY CERTIFY, That I attended deceased from 19....., 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:

Chronic Myocarditis
131
93 C
Chronic Interstitial Nephritis
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Biopsy
(Signed) Alfred C. Gandy, M. D.
6/28, 1928 (Address) Deputy Coroner

*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 Forest Hill DATE OF BURIAL 6-30 1928

20. UNDERTAKER Ceylar Funeral Home ADDRESS

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.

WHITE PRINT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

—If a form of information about an activity is needed, AGC should be listed. PHYSICIANS should state
OF DEATH in plain text. Exact statement of OCCUPATION. State

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson
Township H. City
City H. City

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 2801
St. Ward

2. FULL NAME

Laura Kemper

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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

PARENTS
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)

14. INFORMANT (Address)

15. FILED 6/30 19 28 M M Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 19 28

17. 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.

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CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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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)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

M M Brown

PHYSICIANS should REGISTER WITH UNPAID CAUSE REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UP L THIS Y ARE COMPLETE AS PRESCRIBED BY LAW

