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

Do not use this space.

8915

1. PLACE OF DEATH

County ..... Registration District No. 78

Township ..... Primary Registration District No. 1002

City St. Louis (No. City Hospital ..... St. ..... Ward)

File No. .....

Registered No. 2611

2. FULL NAME William Kemp

(a) Residence. No. 3659a Russell St., 17 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

17486

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 – 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	6		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grinter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

55

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

1

PARENTS

10. NAME OF FATHER William Kemp

2

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

12. MAIDEN NAME OF MOTHER Rebecca Chalk

2

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

14. ~~Hospital Information~~
INFORMANT E. Rowan
(Address) City Hospital

15. FILED ....., 19.. Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1929, to Feb 24, 1929, that I last saw him alive on Feb 24, 1929, and that death occurred, on the date stated above, at 9:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy due to Rt. sided cerebral hemorrhage.
82A

(duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (SECONDARY) 7401

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ~~No~~

0 DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. Berg M.D.

2/25, 1929 (Address) City Hospital

*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
Park Lawn	Feb 28 1929
20. UNDERTAKER	**ADDRESS**
Mullen Und Co	5165 Delmar

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.

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