

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

Do not use this space.

43265

1. PLACE OF DEATH

County Warren Registration District No. 882
 Township H. C. Brown Primary Registration District No. A535
 City Spring City No. _____ St. _____ Ward _____

File No. _____
 Registered No. 21

2. FULL NAME

Richard J. Gempff
 (a) Residence. No. _____ U. 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 male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF widowed
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17 - 1845
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
84 7 2
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired seaman keeper
 (b) General nature of industry, business, or establishment in which employed (or employer) former merchant
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) St. Louis Mo.

10. NAME OF FATHER Fr. J. Gempff
11. BIRTHPLACE OF FATHER (CITY OR TOWN), (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Sophia Hoffmann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN), (STATE OR COUNTRY) Germany

14. INFORMANT Oscar Gempff
 (Address) Spring City Mo

15. FILED 12/29/24 EA Theesmeier M.D.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1929, to Dec 19 1929
 that I last saw him alive on Dec 17 1929 and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
131
 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 129a
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Urinary
 (Signed) W. O. Clearenbach, M. D.
172, 1929 (Address) Wright City 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wright City Cemetery **DATE OF BURIAL** Dec. 22 1929

20. UNDERTAKER Wright City Mo
Wright City Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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 JAN 12 1930

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