

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

Do not use this space.

19626

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis Mo. (No. 1)

Registration District No. 11791  
Primary Registration District No. 11791  
Sanit. 11791

File No.....  
Registered No. 2634  
St. .... Ward)

**2. FULL NAME**

Frank Kemp Jr.  
(a) Residence. No. 931 N. 10<sup>th</sup> St. 13 Ward.  
(Usual place of abode)  
Length of residence in city or town where death occurred 51 yrs. 5 mos. 16 da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Willie Mae Kemp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 25, 1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>51</u>	<u>5</u>	<u>15</u>	

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER..... Unknown

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

12. MAIDEN NAME OF MOTHER..... Unknown

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

14. INFORMANT..... Dr. Mullins Med.  
(Address)..... 5300 Arsenal St.

15. FILED..... 19 11 REGISTRAR W. C. Starling

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 10 1930

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Mar 10, 1930 that I last saw him alive on 3 - 9, 1930, and that death occurred, on the date stated above, at 3:30 a m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chr Myocarditis  
935 (duration) yrs. 9 mos. 1 ds.

CONTRIBUTORY (SECONDARY) NO (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF.....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical test  
(Signed) Dr. Mullins, M. D.

3-10-1930 (Address) 5300 Arsenal St.

\*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 <u>Greenwood</u>	DATE OF BURIAL <u>3/10 1930</u>
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20. UNDERTAKER <u>C. W. Roberts</u>	ADDRESS <u>3035 Lucas</u>
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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.

