

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

Do not use this space.

12806

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1135
 Township Kan Primary Registration District No. 1003 Registered No. 1135
 City Kansas City (No. Kansas City General Hospital St. _____ Ward)

2. FULL NAME

Kempster George
 (a) Residence. No. 4024 Bab St. 7 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-3-1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>3</u>	<u>1</u>	<u>16</u>	

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Edward Kempster

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

12. MAIDEN NAME OF MOTHER Benton

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

14. INFORMANT Richard Clark
 (Address) Kansas City Gen Hosp.

15. FILED 4/21 1930 M. M. Crowl
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-19-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-13-1930 to 4-19-1930
 that I last saw him alive on 4-19-1930 and that death occurred, on the date stated above, at 9:40a m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Epidemic cerebrospinal meningitis

18 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 24 (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? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) P. E. Williams, M. D.

4-19-1930 (Address) Dept. K. B. Gen Hosp.

*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 Calvary Cemetery DATE OF BURIAL 4/21 1930

20. UNDERTAKER Frank E. Tobin 20 W. Lincoln ADDRESS _____

K. 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.

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

