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

Do not use this space.

17433

1. PLACE OF DEATH

County ..... Registration District No. [illegible]

Township ..... Primary Registration District No. [illegible]

City St Louis (No. 3731 Bamberger St. ..... Ward)

File No. .....

Registered No. 4501

2. FULL NAME Mamie Kempe

(a) Residence. No. 3731 Bamberger St., 15 Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 15 - 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	48	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Bernard Schwake
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

14. INFORMANT Herman Kempe
(Address) 3731 Bamberger

15. FILED ....., 19.. [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3rd 1930

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to May 3rd, 1930 that I last saw her alive on May 3rd, 1930 and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis (Pulmonary)
23 A

..... (duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY ~~(SECONDARY)~~ 31

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Not known
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) Fred W Rolling, M. D.
5/4, 1930 (Address) 2125 Sidney 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	DATE OF BURIAL
St. Trinity Lutheran	May 6 1930
20. UNDERTAKER	**ADDRESS**
Wacker Helderle	2331 S Bdwy

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.