

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

Do not use this space.

1501

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Steu Primary Registration District No. _____
 City Kansas City (No. St. Hosp #2)

File No. _____
 Registered No. 233
 St. _____ Ward _____

2. FULL NAME

Edward Kemp
 (a) Residence. No. 922 Bell St. 3 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 21 1931

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

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1931, to Jan. 21, 1931.
 that I last saw him alive on Jan. 21, 1931, and that death occurred, on the date stated above, at 11:05 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1868

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Embolism
and Thrombosis
1567
978 (duration) _____ yrs. _____ mos. _____ ds.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
62

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
 (duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Before
 (b) General nature of industry, business, or establishment in which employed (or employer). 922 Bell
 (c) Name of employer _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Jan 16, 1931

9. BIRTHPLACE (CITY OR TOWN) Hannibal
 (STATE OR COUNTRY) MO.

10. NAME OF FATHER Asley Kemp

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

12. MAIDEN NAME OF MOTHER Melinda

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

14. INFORMANT Henry Kemp
 (Address) 5151 St. 7th

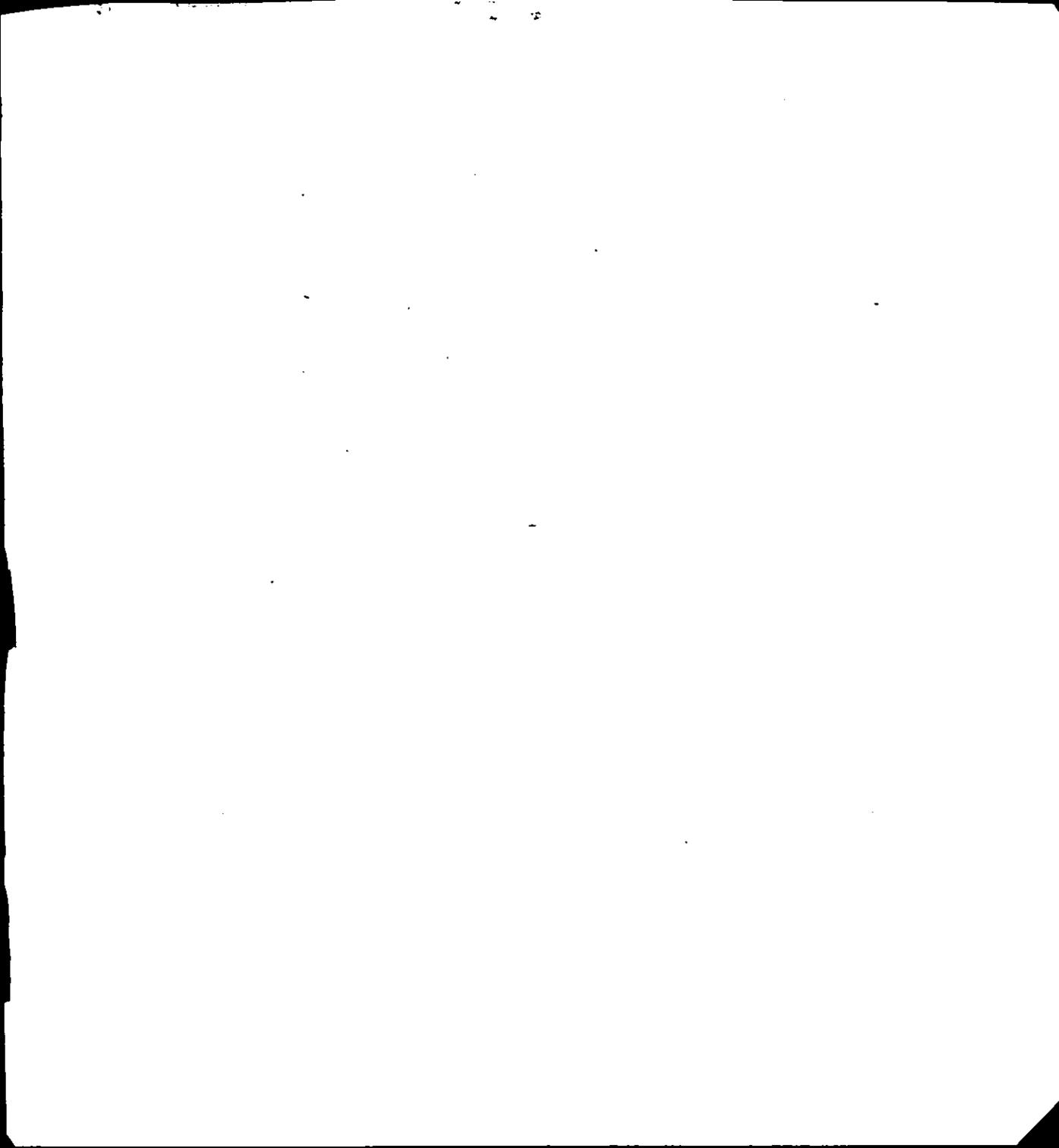
WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) D. M. Milled M. D.
1/21/31, 19 (Address) St. Hosp #2

15. FILED 1-23, 1931 M. M. Brown
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge Lawn DATE OF BURIAL 1/24 1931

20. UNDERTAKER Natkins Bros ADDRESS 1709 Lyde

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. *2376*
 City..... (No. *General Hoop #*) St. Ward)

2. FULL NAME

Edw Kemp
 (a) Residence. No. *222 Bell St.* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 27th 1931*

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

17. I HEREBY CERTIFY That I attended deceased from 19.....
 that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Embolism and Thrombosis

7. AGE YEARS MONTHS DAYS IF LESS than I day, hrs. or min.
62

CONTRIBUTORY (SECONDARY) *Arterio sclerosis*
 (duration)..... yrs. mos. ds.

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

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

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

Did an OPERATION PRECEDE DEATH? *Yes* DATE OF OPERATION *Jan 16 - 1931*
 WAS THERE AN AUTOPSY? *operation for aneurysmal structure*

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED *1/23* 19 *31* *M M. Croome* REGISTRAR

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

