

OCT 12 1939

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

32040

Do not use this space.

1. PLACE OF DEATH

(a) County Callaway 2 Registration District No. 104
(b) Township Fulton 1 Primary Registration District No. 3008
(c) City Fulton (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Charles Mordecai Kemp
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jane Kemp
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 5 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 9 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. x
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (year) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) Bachelor Mo.
(STATE OR COUNTRY)

FATHER 13. NAME John D. Kemp
14. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

17. INFORMANT Mrs. John W. McCann
(ADDRESS) Mexico, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bachelor DATE Sept. 28 1939

19. FUNERAL DIRECTOR (NAME) Hughes Manpin
(ADDRESS) Aux Vaca, Mo.

20. FILED Sept 28 1939 R. N. Creve
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 28 1939

22. I HEREBY CERTIFY That I attended deceased from Sept. 27 1939 to Sept 28 1939
I last saw him alive on Sept 28 1939. Death is said to have occurred on the date stated above, at 6:30 A.M.
The principal cause of death and related causes of importance were as follows:

Shock
Fractured ribs in thoracic vertebrae
Spinal cord injury & rupture
Date of onset 9-28
9-28

Other contributory causes of importance: None
Name of operation none Date of _____
What test confirmed diagnosis? x-ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 9-28 1939
Where did injury occur? Aux Vaca, Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury Fall from ladder
Nature of injury Broken back

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) John J. Brown, M. D.
(Address) Fulton, 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Hughes Maupin*
Licensed Embalmer No. *2358*
P. O. Address *Cheyenne, Wyo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

PROVIDED FOR THE STATE OF WYOMING
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
EMBALMERS
1954

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32040
Do not use this space.

1. PLACE OF DEATH
 (a) County Pallaway Registration District No. 104
 (b) Township _____ Primary Registration District No. 3008 Registered No. 271
 (c) City Fulton (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Charles Mordecai Kemp
 (a) Residence, No. _____ St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>9</u>	<u>23</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER

13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____, 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 28 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) John J. Brown, M. D.
 (Address) Fulton, Mo

SUPPLEMENTARY

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY I

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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