

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.

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

39106  
 Do not use this space.

**1. PLACE OF DEATH** 3  
 (a) County..... Buchanan ..... Registration District No..... 85  
 (b) Township..... 1 ..... Primary Registration District No..... 1001  
 (c) City..... St. Joseph ..... (d) Street No. 1010 Henry ..... 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 45 yrs. - mos. - ds. (f) How long in U. S., if of foreign birth? 45 yrs. - mos. - ds.

**2. PRINT FULL NAME** 512 Julia Kempka  
 (a) Residence, No. 2014 Colhoun 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 Female      4. COLOR OR RACE White c      5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 22, 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	79	10	8	

OCCUPATION: 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
 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)** Unknown Germany 6

**FATHER**  
 13. NAME Brostovitch Dominick 6  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Germany 6

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

17. INFORMANT (ADDRESS) Andrew Kempka 2014 Colhoun Str. St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Olivet Cent. St. Joseph, Mo. DATE Dec. 2, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H.C. Sidenfaden & Son 1802 Union Str. St. Joseph, Mo.

20. FILED Beck, 19 39 H.C. Neathbrush Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1939, to Nov 30, 1939  
 I last saw h. er alive on Nov 30, 1939. Death is said to have occurred on the date stated above, at 6:15 AM.  
 The principal cause of death and related causes of importance were as follows:  
Myocardial insufficiency chronic unknown

Date of onset 1939

Other contributory causes of importance:  
Arteriosclerosis General unknown

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? no

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? no  
 If so, specify \_\_\_\_\_  
 (Signed) Arthur J. Rau, M. D.  
 (Address) Historical Bldg, St. Joseph, Mo.

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT  
DATE 1 9

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**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 Robert P. Carlson

Licensed Embalmer No. 4028

P. O. Address St. Joseph, Mo.

**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.**