

FILED OCT 18 1940

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

32448

Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 1491
(b) Township Bedford Primary Registration District No. 4298
(c) City Troy (d) Street No. _____ Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ernest A. Kemper
(a) Residence, No. Troy Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) <u>Alice Sin Kemper</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 14 1874</u>				
7. AGE	YEARS <u>65</u>	MONTHS <u>10</u>	DAYS <u>25</u>	IF LESS than 1 day, hrs. or min.
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. <u>undertaker</u>			
	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) <u>Troy Mo.</u>				
FATHER	13. NAME <u>Henry W. Kemper</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>			
MOTHER	15. MAIDEN NAME <u>Elizapeth Winkler</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>			
17. INFORMANT (ADDRESS) <u>S. F. Kemper</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>City Cemetery</u> DATE <u>Sept 14 1940</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Kemper Bros</u> <u>Troy Mo.</u>				
20. FILED <u>Sept 9 1940</u> <u>Mrs. Pearl Truck</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 8. 1940
22. I HEREBY CERTIFY, That I attended deceased from Sept. 8. 1940 to Sept 8 1940
I last saw him alive on Sept 8 1940 Death is said to have occurred on the date stated above, at 10 p. m.
The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset

Other contributory causes of importance:

arterial Hypertension

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) H. S. Harris, M. D.
(Address) Troy, Mo.

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

Julius J. Nieburg

Licensed Embalmer No. *3366*

P. O. Address *Wright City, 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.

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-40
2659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32448

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 491

Primary Registration District No. 4298

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Levy
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Ernest A. Kemper

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 25 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept. 9-40 (b) Mrs Pearl Munk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
I have last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. S. Harris (M. D. or other) _____

Address Levy Mo Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

