

NOV 15 1940

Registration District No. **193**

Primary Registration District No. **5270**

Registrar's No. _____

1. PLACE OF DEATH: **Clark**
 (a) County **Clark**
 (b) City or town **Wayland Des Moines**
 (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 **2**
 In this community **nearly all of life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Clark**
 (c) City or town **Wayland**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **0**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **Campbell Chapman Kemper**
 3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov**, day **8**, 19**40**
 year **Eleven** hour **Thirty** minute **A.** M.

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **October 17, 1864**
 (Month) (Day) (Year)

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

8. AGE: Years **76** Months **0** Days **21** If less than one day _____ hr. _____ min.

Immediate cause of death **Died Suddenly Coronary Occlusion**
 Due to _____
 Due to _____

9. Birthplace **Clark Co. Mo.**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Retired Laborer**

Other conditions (Include pregnancy within 3 months of death) **94 13**
 Major findings:
 Of operations _____
 Of autopsy _____

MOTHER FATHER
 12. Name **John Walker Kemper**
 13. Birthplace **Virginia**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Elizabeth Pence**
 15. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Jack Dennison**
 (b) Address **Keokuk, Iowa**
 17. (a) **Burial** (b) Date thereof **Nov 10 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

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?
177 (Specify type of place) (e) Means of injury _____

(c) Place: burial or cremation **Sand Cemetery**
 18. (a) Signature of funeral director **H. F. Kircher**
 (b) Address **Wayland, Mo.**
 19. (a) **11/8, 1940** (b) **H. F. Kircher**
 (Date received local registrar) (Registrar's signature)

23. Signature **H. A. S. Rebo** (M. D. or other) **corner 5**
 Address **Nov 8 - 1940** Date signed _____
Alexandria, Mo.

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

RECEIVED

District Health Officer No. 10

District File Number 11-40-2107

Date Filed NOV 11 1940

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.....

Vernon C. Ryan

Registered Apprentice No. 264

working under my personal supervision.

Signed.....

H. G. Kircher

Licensed Embalmer No. 2611

P. O. Address Wayland, 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, fact should be so stated above.