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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6593

State File No. \_\_\_\_\_  
Registrar's No. 241

Registration District No. 42 Primary Registration District No. 1008

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: St. Joseph's Hospital  
(d) Length of stay: In hospital or institution. Life-time.  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(d) Street No. 3010 Edmond St.  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Teresa Kempf  
3. (b) If veteran, name war. No.  
3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 7 year 1944 hour 2 minute 00 P.M.  
21. I hereby certify that I attended the deceased from Feb 29 1944 to March 7 1944  
that I last saw him alive on March 7 1944 and that death occurred on the date and hour stated above.

4. Sex Female  
5. Color or race White  
6. (a) Single, widowed, married, divorced, Widow  
6. (b) Name of husband or wife Louis Kempf  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased September 17 1860

Immediate cause of death: Care, none of stomach  
Due to: Severe anemia and to gastric hemorrhage  
Other conditions:  (Include pregnancy within 3 months of death)  
Major findings: Of operations:   
Of autopsy:

8. AGE: Years 73 Months 5 Days 20  
9. Birthplace St. Joseph Missouri  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Michael Miller  
13. Birthplace Unknown Germany  
14. Maiden name Anna Fuchs  
15. Birthplace Unknown Germany

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

16. (a) Informant Mrs. Wm Kempf  
(b) Address 1401 So. 16th St.  
17. (a) Burial (b) Date thereof March 10 1944  
(c) Place: burial or cremation Mt. Olivet Cemetery  
18. (a) Signature of funeral director Herman W. Sidenfaden  
(b) Address 1802 Union St., St. Joe, Mo.  
19. (a) 3-10-44 (b) Rose George

23. Signature Gustav Han (M. D. or other)  
Address St. Joseph Mo Date signed 3/8/44

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

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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 H Reed* .....

Licensed Embalmer No. *3745* .....

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, fact should be so stated above.**

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 241

1. PLACE OF DEATH:

(a) County Buchanan  
 (b) City or town St. Joseph  
(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 Teresa Kempf

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 17 1900  
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days \_\_\_\_\_  
Unless than one day \_\_\_\_\_ min.

9. Birthplace St. Joseph, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Rae Helzog  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March  
 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I 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 \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

0593