S. No. 2
M—5-42
5-17-39
P I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14694

State File No.

FILED MAY 9 1945

Registration District No. 9 1945

Primary Registration District No. 2000

Registrar's No. 373

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: O'Reilly General Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days (Specify whether
In this community 24 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin (b) County Sawyer 999

(c) City or town Radisson
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1 47
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME WARREN F. KEMMITS

3. (b) If veteran, name war World War II

3. (c) Social Security No. None

4. Sex Male O

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased January (Month) 2, (Day) 1925 (Year)

8. AGE: Years 19 Months 3 Days 26 If less than one day hr. min.

9. Birthplace St. Peter (City, town, or county) Minnesota (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER
12. Name William A. Kemmits
13. Birthplace St. Peter (City, town, or county) Minnesota (State or foreign country)

MOTHER
14. Maiden name Viola Flum
15. Birthplace Fayette (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Mrs. Viola Kemmits
(b) Address Radisson, Wisconsin

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof April 29, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Ladysmith, Wisconsin

18. (a) Signature of funeral director [signature]
(b) Address Springfield Mo

19. (a) 4-28-44 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1944 hour 12 minute 05 A. M.

21. I hereby certify that I attended the deceased from April 5, 1944, to April 28, 1944; that I last saw him alive on April 28, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	14 days
Due to Nephritis, acute, severe, post-scarlatinal	18 days
Due to Scarlet fever (cured Feb. 14, 1944)	23 ds.

Other conditions Arterial hypertension, severe, and Myocardial insufficiency, severe.
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operations

Of autopsy Confirmation of above diagnoses.

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Lee Stover, Capt MC (M. D. or other)

Address O'Reilly General Hospital Springfield, Mo. Date signed 4/28/44

(Licensed Embalmer's Statement on Reverse Side)

A report submitted to the Bureau of the Census.

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 H L McCann

Licensed Embalmer No. 2727

P. O. Address 458 E Walnut

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.