

FILED MAY 11 1944

Registration District No. 553

Registrar's No. 57-63

1. PLACE OF DEATH:

(a) County Madawaska  
(b) City or town Mayville  
(c) Name of hospital or institution: #3 Rural  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution about 5 yrs  
In this community about 5 yrs  
years, months or days

3. (a) PRINT FULL NAME

Donald Robert Kempf

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 —

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

7. Birth date of deceased Dec 10 1937  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 4 4 hr. min.

9. Birthplace N.E. of Barnard Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER, FATHER { 12. Name Charles Kempf  
13. Birthplace Buchanan County Missouri  
14. Maiden name Cona Brunk  
15. Birthplace Atchison County Missouri

16. (a) Informant Charles Kempf  
(b) Address Mayville Mo  
17. (a) Burial (b) Date thereof 4-17-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri  
18. (a) Signature of funeral director Campbell Funeral Home  
(b) Address Mayville Missouri  
19. (a) 4-18-44 (b) Chas Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madawaska  
(c) City or town Mayville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4 Miles E 1/2 North (If rural, give location)  
(e) Citizen of foreign country? — (Yes or No)  
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR day 14  
year 1944 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Dec. 7, 1943  
1943 to Apr. 14, 1944  
that I last saw him alive on Apr. 10, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral sinus thrombosis 3 mo.  
(Infectious)  
Due to T. Pneumatis fever 2 mo.

Due to 582  
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations —  
Of autopsy —

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) (e) Means of injury —  
23. Signature W. L. Sandfather (M. D. or other) DO  
Address Mayville Mo Date signed 4-17-44

Duration  
3 mo.  
2 mo.  
PHYSICIAN  
Underline the cause to which death is attributed.

**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.....

*Majorie Lulu Campbell*, Registered Apprentice No. *360*  
working under my personal supervision.

Signed.....

Licensed Embalmer No. *2620*

P. O. Address.....

*Maripolo N*

**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.**