

FILED NOV 23 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1009

Registrar's No. 9856

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis Mo
(c) Name of hospital or institution: Barnes Hospital
(d) Length of stay: 11 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Clinton
(c) City or town Carlyle
(d) Street No. _____
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Edward Hempen

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

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 August 20 1909
(Month) (Day) (Year)

8. AGE: Years 36 Months 2 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Mechanic

11. Industry or business _____
12. Name Leo C. Hempen, Sr.

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

14. Maiden name Anna Meier

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

16. (a) Informant Henry Hempen

(b) Address Carlyle, Ill.

17. (a) Removal (b) Date thereof 11-12-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carlyle, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 14 1945 (b) J. R. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 10th
year 1945 hour 9 minute 35 - P.M.

21. I hereby certify that I attended the deceased from October 30 1945 to November 10th 1945
that I last saw him alive on November 10th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of kidney Duration 1 year

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

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

23. Signature J. R. Bradeck (M.D. Registrar)
Address Barnes Hospital Date signed 11/14/45

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

MOTHER FATHER

9856

9856

laewell

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed..... *Abriel G. Happe*

Licensed Embalmer No..... *2971*

P. O. Address.....

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.