

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30024

FILED NOV 20 1946

State File No. _____

Registration District No. _____

Primary Registration District No. 4022

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Butterfield
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dora Francis Kemp

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female 5. Color or race white

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

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

7. Birth date of deceased January 6 1882
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 12th
year 1946 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from Aug 1943 to Nov 12 1946
that I last saw her alive on Nov 11 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>10</u>	<u>6</u>	hr. _____ min.

Immediate cause of death non-specific Coagulation of Blood

Due to Hypertension?

Due to myocarditis

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Fayetteville Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Ed. Edwards

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

14. Maiden name Jane McDunnen

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

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Cleo Duffey

(b) Address Butterfield, Missouri

17. (a) Burial (b) Date thereof 11-14-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Church

18. (a) Signature of funeral director Culver Funeral Home

(b) Address Cassville, Missouri

19. (a) Nov 14 - 1946 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

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)

(e) Means of injury _____

23. Signature W. R. McClure (M. D. or other) RD

Address Cassville Date signed 4/23/46

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

MOTHER FATHER

RECEIVED
District Health Officer No. 6,
District File Number 1146-1147
Date Filed NOV 18 1946

ЗАК—ЛІВРЕ: У БЕКІВІВІЕВ. РЕКОРД

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 Margaret Culver
Licensed Embalmer No. 4389
P. O. Address Cassville

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. 11

Primary Registration District No. 4022

1. PLACE OF DEATH:
(a) County Barry Butterfield
(b) City or town _____
(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 _____ (Specify whether _____)
years, months or days

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 _____

3. (a) PRINT FULL NAME Dora F. Kemp
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
Year 1946 (hour) _____ minute _____ M.

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mr. Kemp 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased: Jan (Month) _____ (Day) _____ (Year)

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

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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)

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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? _____ (c) Means of injury _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY 2

WRITE PLAINLY—USE UNFADING BLACK INK

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

30024