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FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15614

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 454

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN North Campbell		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN North Campbell	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2616 W. State	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2616 W. State			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) F.	c. (Last) Kemp	4. DATE OF DEATH (Month) (Day) (Year) May 20 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 13 1892	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 100 Hrs. Days	IF UNDER 1000 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insulator	10b. KIND OF BUSINESS OR INDUSTRY Insulator	11. BIRTHPLACE (State or foreign country) Colorado	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Alfred Kemp	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mary Kemp
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 491-03-1226	17. INFORMANT'S SIGNATURE OR NAME Mary K. Kemp	ADDRESS Springfield
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) probably coronary thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		not attended by a physician	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE W. E. Dandley MD Local Registrar (Degree or title)	23b. ADDRESS City Hall, Springfield Mo	23c. DATE SIGNED 5/20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 24, 1949	24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Missouri
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DATE REC'D BY LOCAL REG. 5/23/49	REGISTRAR'S SIGNATURE W. E. Dandley MD	25. FUNERAL DIRECTOR'S SIGNATURE J. W. K. Kugner & Co.	ADDRESS Spfld
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 19 1949

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.

Student Embalmer No. _____

Signed _____

Max A. Hodus

Signed _____
Student Embalmer

Licensed Embalmer No. _____

4071

P. O. Address _____

Springfield

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.