

FILED FEB 16 1951
#65606

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6293
1209

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	2139
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u>		d. STREET ADDRESS (If rural, give location) <u>5800 Arsenal St.</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>LILLIAN</u>	b. (Middle)	c. (Last) <u>KEMPIN</u>	Feb.	6th,	1951

5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Apr. 14 1876</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 12 HRS. Hours	IF UNDER 12 HRS. Min.
-------------------------	----------------------------------	--------------------------------------------------------------------------	-----------------------------------------	----------------------------------------------	---------------------------	-------------------------	---------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY?
------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------	--	------------------------------

13a. FATHER'S NAME <u>Wm. H. Rothschild</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Fochs</u>	14. NAME OF HUSBAND OR WIFE <u>George W. Kempin</u>	
------------------------------------------------	------------------------------------------------	--------------------------------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm. Rothschild; 6264 Enright Ave.</u>	
----------------------------------------------------------------------------------------------------------	-------------------------	---------------------------------------------------------------------------------------	--

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	<p align="center">MEDICAL CERTIFICATION.</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastrocolic fistula</u></p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>adenocarcinoma of colon</u> DUE TO (c)</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>untetm</u>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--	--------------------------------------------------------------------------

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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

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? <u>152X</u>
--------------------------------------------------------	--------------------------------------------------------------------------------------------------------	-------------------------------------------

22. I hereby certify that I attended the deceased from 12/6/50, 19 , to 2/6/51, 19 , that I last saw the deceased alive on 2/6/51, 19 , and that death occurred at 2:30am m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Gary B. Wood M.D.</u>	23b. ADDRESS <u>1515 Lafayette Ave.,</u>	23c. DATE SIGNED <u>2/6/51</u>
--------------------------------------------------------------	---------------------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>2/7/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
------------------------------------------------------------	----------------------------	------------------------------------------------------------	-----------------------------------------------------------------------

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>FEB 7 1951 J. B. Luster</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral; 1905 Union Blvd.</u>
-----------------------------------------------------------------------------	--------------------------------------------------------------------------------------

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

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 Warren A. Carver

Signed.....
Student Embalmer

Licensed Embalmer No. 353K

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.