

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37394

State File No.

5102

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

4

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 2631 Agnes	
d. FULL NAME OF HOSPITAL OR INSTITUTION DeLora Rest Home			

3378

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) c. (Last) KEMPER			4. DATE OF DEATH (Month) (Day) (Year) 11 27 51		
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 11-28-1872	9. AGE (In years less birthday) 78	IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY xx	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Casper Kemper	13b. MOTHER'S MAIDEN NAME Mary Bockrath	14. NAME OF HUSBAND OR WIFE xx
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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. None	17. INFORMANT'S SIGNATURE OR NAME Miss Leona Jakobe ADDRESS 305 E. 70th Terr.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Abdominal Spleen		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?

22. I hereby certify that I attended the deceased from July 8, 1944, to Nov. 27, 1951, that I last saw the deceased alive on Nov. 25, 1951, and that death occurred at 8:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE Harold A. Pallett MD	23b. ADDRESS 1132 Prof. Blvd. K.C. Mo.	23c. DATE SIGNED 11/28/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-30-51	24c. NAME OF CEMETERY OR CREMATORY Forest Hill
24d. LOCATION (City, town, or county) Kansas City		(State) Mo.

DATE REC'D BY LOCAL REG. 11-28-51	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE J. W. Wagner ADDRESS K C Mo.
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11-1486

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed A. R. Haunschuld

Licensed Embalmer No. 4159

P. O. Address K. C. MO.

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.