

FILED AUG 8 - 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHDr. Wakeman  
State File No. 24440

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 722

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>STONE</b>					
b. CITY OR TOWN <b>SPRINGFIELD</b>		c. LENGTH OF STAY (in this place) <b>7 MO</b>		c. CITY OR TOWN <b>CRANE</b>		1040			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>721 N. FREMONT</b>				d. STREET ADDRESS (If rural, give location)					
3. NAME OF DECEASED (Type or Print) a. (First) <b>RACHEL</b>			b. (Middle) <b>E.</b>		c. (Last) <b>KEMP</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>AUGUST 2, 1953</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>OCT. 22, 1880</b>		9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	IF UNDER 1 MIN. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ROVER, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>UNKNOWN</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>* * * * *</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS R. D. SUMMERS</b>				ADDRESS <b>CRANE, MISSOURI</b>	
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)				<b>Hemorrhage, cerebral.</b>				<b>2 days</b>	
ANTECEDENT CAUSES				DUE TO (b) <b>Arteriosclerosis.</b>					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) <b>Hypertension.</b>					
II. OTHER SIGNIFICANT CONDITIONS				<b>Arthritis Rheumatoid</b>					
Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		<b>331X</b>							
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)		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 <b>April</b> , 19 <b>53</b> , to <b>August 2</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>August 1</b> , 19 <b>53</b> , and that death occurred at <b>4:40 p.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Walter Wakeman M.D.</b>				23b. ADDRESS <b>Springfield Mo.</b>		23c. DATE SIGNED <b>8-4-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8/4/53</b>	24c. NAME OF CEMETERY OR CREMATOR <b>Wright cemetary</b>		24d. LOCATION (City, town, or county) (State) <b>Near Clever, Missouri</b>				
DATE REC'D BY LOCAL REG. <b>8-3-53</b>		REGISTRAR'S SIGNATURE <b>Edith Williamson</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Herman H. Lohmeyer, Springfield</b>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Bruce Johnson*

Licensed Embalmer No. *4734*

P. O. Address *Spfld, Ill*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.