

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Paul N. Johnstone

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4810

STATE FILE NUMBER  
431

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 431

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>			Length of stay in lb <b>12 yrs</b>		d. STREET ADDRESS (If outside, give location) <b>4411 Benton Blvd.</b>
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle <b>BELINDA</b> Last <b>KEMP</b>			4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 9, 1883</b>	9. AGE (In years last birthday) <b>74 7/8</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLK. at General Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>LAMONT, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>GEORGE W. KEMP</b>			14. MOTHER'S MAIDEN NAME <b>SARAH B. EWING</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>496-36-8576</b>		17. INFORMANT <b>KEMP</b> Address <b>Wm A. Fapp - Bro. 4411 Benton Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Circulatory Failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Focal Fibrinopurulent Peritonitis</b>					<b>UNKNOWN</b>
DUE TO (c) <b>Primary Annular Obstructive Carcinoma of sigmoid colon with metastasis</b>					<b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.					19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>1</b>		
20c. TIME OF INJURY: Hour - Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>January 23, 1957</b> to <b>January 28, 1957</b> and last saw her <sup>alive</sup> on <b>January 27, 1957</b> . Death occurred at <b>9:40 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Paul N. Johnstone, M.D.</b> (Degree or title)			22b. ADDRESS <b>1110 Bryant Bldg.</b>		22c. DATE SIGNED <b>January 28, 1957</b>
23a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Burial</b>		23b. DATE <b>1-29-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAMONT</b>		23d. LOCATION (City, town, or county) (State) <b>LaMont, Missouri</b>
24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b>		ADDRESS <b>Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-29-57</b>	26. REGISTRAR'S SIGNATURE <b>Alva Minshall</b>

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.....  
Signature of Student Embalmer

Signed.....  
*J. T. Crowell*

Licensed Embalmer No. .... 4

P. O. Address.....  
N.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.