

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

418899
STATE FILE NUMBER
11081
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 38 Paroute City Hospital		Length of stay in 1b DOA	d. STREET ADDRESS 164 5119 Greer		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Kenrick Middle V. Last Dempsey			4. DATE OF DEATH November 15, 1957 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 12, 1913		9. AGE (In years last birthday) 44 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claim Clerk		10b. KIND OF BUSINESS OR INDUSTRY Cotton Belt R.R.	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Kenrick L. Dempsey		13b. MOTHER'S MAIDEN NAME Florence Keene		14. NAME OF HUSBAND OR WIFE Agnes	
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. 702-09-6746	17. INFORMANT Address Kenrick L. Dempsey, 2005 So. Grand Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) _____ 490x					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
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.)		
20c. TIME OF INJURY .Hour _____ Month, Day, Year a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 _____ and last saw her alive on _____ Death occurred at 6:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE James M. Kelly, Deputy		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 11-19-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-20-57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo. (State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. NOV 19 57		26. REGISTRAR'S SIGNATURE Earl Smith <i>m & B.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Securing the medical certification in this manner required by 193.140 RSMo is required.

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.

