

Health, Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046790

STATE FILE NUMBER

FILED JAN 6 1959

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3317

300 4  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death sign) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ellisville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rural Meramec Twsp. 4000</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sunset Sanatorium</b>		Length of stay in 1b <b>2 Yrs 8 Mos.</b>	d. STREET ADDRESS (If outside, give location) <b>Strecker Rd.</b>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Kempf</b> Last <b>Kempf</b>			4. DATE OF DEATH Month <b>Dec</b> Day <b>17</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-16-1872</b>	9. AGE (In years at birthday) <b>86</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Vincent Friedrich</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Doering</b>	14. NAME OF HUSBAND OR WIFE <b>August Kempf</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT <b>Dorothy Friedrich Valley Park, Mo.</b>	Address
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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>Arteriosclerosis about base of brain</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>unknown</b>	
	DUE TO (c) <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>4200</b>
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20c. TIME OF INJURY Hour <b>6:25</b> Month, Day, Year a.m. <b>12-17-58</b> p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>1042 E. Manchester</b>	20f. CITY, TOWN, OR LOCATION <b>Manchester, Mo.</b>	COUNTY	STATE
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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.) <b>1042 E. Manchester</b>	20f. CITY, TOWN, OR LOCATION <b>Manchester, Mo.</b>	COUNTY	STATE
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21. I attended the deceased from <b>1 Aug 58</b> to <b>12-17-58</b> and last saw her/him alive on <b>12-17-58</b> Death occurred at <b>6:25 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>G. H. Barnett</b>	22b. ADDRESS <b>1042 E. Manchester, Manchester, Mo.</b>	22c. DATE SIGNED <b>12-19-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-20-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Manchester, Mo.</b>
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24. FUNERAL DIRECTOR <b>Schrader Funeral Home Ballwin, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-19-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Dombke</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Richard M. Bopp* .....

Licensed Embalmer No. *4584*  
P. O. Address *Ballwin, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.