

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006763  
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN O'FALLOON Mo
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph		Length of stay in lb 2 months	d. STREET ADDRESS (If outside, give location) RR1
3. NAME OF DECEASED (Type or print) First Clem Middle L? Last Kemper			4. DATE OF DEATH Feb. 11 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 61
13a. FATHER'S NAME Casper Kemper		13b. MOTHER'S MAIDEN NAME Kampton	14. NAME OF HUSBAND OR WIFE Agnes Kemper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of discharge) YES 1918		16. SOCIAL SECURITY NO. 498-18-8861	17. INFORMANT Henry Kemper O'Fallon Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Atherosclerotic Head Disease DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) Parkinsons Disease			INTERVAL BETWEEN ONSET AND DEATH 33 days
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.) 4200	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 12-8-58 to 1-10-59 and last saw him alive on 1-10-59 Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Gene J. Swinton MD (Degree or title)		22b. ADDRESS O'Fallon, Mo	22c. DATE SIGNED 2-11-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 13 1959	23c. NAME OF CEMETERY OR CREMATORY Assumption	23d. LOCATION (City, town, or county) (State) O'Fallon Mo.
24. FUNERAL DIRECTOR E. A. Keilly O'Fallon Mo		25. DATE RECD. BY LOCAL REG. Feb 14-59	26. REGISTRAR'S SIGNATURE Marcilla Wilson

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

FEB 25 1959

MAR 3 1959

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 ..... *E. K. Keithly*

Licensed Embalmer No. *872*

P. O. Address ..... *Wallow*

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.