

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016122
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1175

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		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 Kirkwood		c. CITY OR TOWN Maplewood <i>4524</i>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Oark Nursing Home		d. STREET ADDRESS (If outside, give location) 2518 Oakland Ave.	
Length of stay in lb 2 Wks.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last Annie NMI Kempf			4. DATE OF DEATH Month Day Year April 28th 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17th 1884
9. AGE (In years and months) (If under 1 year, give month and day) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Michael Queenan	13b. MOTHER'S MAIDEN NAME Louise Bile
14. NAME OF HUSBAND OR WIFE Henty J. Kempf		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. None
17. INFORMANT 3647 Oxford Michael Queenan, Maplewood, 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) Hypostatic pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senility & malnutrition DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 522X	
19. INTERVAL BETWEEN ONSET AND DEATH 5 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.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <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 5-20-56 to 4-29-59 and last saw her alive on 4-24-59 Death occurred at 2:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Sterling M.D.</i> (Degree or title)		22b. ADDRESS 7266 Meachester	
22c. DATE SIGNED 4-29-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 5-1-59		23c. NAME OF CEMETERY OR CREMATORY Resurrection	
23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		24. FUNERAL DIRECTOR ADDRESS JAY B. SMITH, Maplewood, Mo.	
25. DATE RECD. BY LOCAL REG. 4-29-59		26. REGISTRAR'S SIGNATURE <i>Jahn C. Murphy M.D.</i>	

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 *J. Allen Davis Jr.*
Licensed Embalmer No. *2053*
P. O. Address *H.R.*

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.