

Public Health, Welfare Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019838

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1336

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-57

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST LOUIS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CLAYTON</b>                         |  | c. CITY OR TOWN <b>OVERLAND 424X</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST LOUIS CO Hosp. Tap</b> |  | d. STREET ADDRESS (If outside, give location) <b>2228 DAWES</b>   |  |
| Length of stay in lb <b>4 DAYS</b>  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|   |                           |   |   |  |   |  |
|---|---------------------------|---|---|--|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>MYRTLE</b> Middle Last <b>KEMPFER</b>                         |                           |   | 4. DATE OF DEATH<br>Month <b>5</b> - Day <b>13</b> - Year <b>1959</b> |  |   |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>APR 12 1876</b>                                   |  | 9. AGE (In years and (ir)thday) <b>83</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b> |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |   | 11. BIRTHPLACE (City and state or country) <b>OHIO</b> |   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                           | 13a. FATHER'S NAME <b>CHAS. HY. WALKER</b>  |   | 13b. MOTHER'S MAIDEN NAME <b>ELIZ. JANE BIGGINS</b>    |   |  |
| 14. NAME OF HUSBAND OR WIFE <b>UNKNOWN</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>NONE</b>                    |   |  |
| 17. INFORMANT <b>LESLIE WALKER SR</b>   |                           | Address <b>8669 HAGNER RD</b>   |   |  |   |  |

|   |                                     |  |
|---|-------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary infection</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Pulmonary embolus</b> |  |
|   | DUE TO (c) _____                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____                     |                                     | 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>465X</b> |   |
| 20c. TIME OF INJURY<br>Hour _____ 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 **5-9-59** to **5-13-59** and last saw <sup>per</sup> <sub>him</sub> alive on **5-13-59**  
Death occurred at **492** m on the date stated above; and to the best of my knowledge, from the causes stated.

|  |  |                        |
|--|--|------------------------|
| 22a. SIGNATURE (Degree or title) <b>Emil Maurer M.D.</b> | 22b. ADDRESS <b>601 S. Brentwood Bl.</b> | 22c. DATE SIGNED _____ |
|--|--|------------------------|

|   |                          |  |  |
|---|--------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> | 23b. DATE <b>5-16-59</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Sunset</b> | 23d. LOCATION (City, town, or county) (State) <b>St Louis MO</b> |
|---|--------------------------|--|--|

|   |   |  |
|---|---|--|
| 24. FUNERAL DIRECTOR ADDRESS <b>Emil Maurer, Overland</b> | 25. DATE RECD. BY LOCAL REG. <b>5-15-59</b> | 26. REGISTRAR'S SIGNATURE (State) <b>John B. Murphy M.D.</b> |
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Maurer, M.D.

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 *E. C. Allen* .....

Licensed Embalmer No. *3501* .....  
P. O. Address *Oakland, Cal.* .....

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.