

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUL 17 1959

59-025234

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3316

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>7 YEARS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSPITAL</b>				d. STREET ADDRESS (If outside, give location) <b>3341 BALTIMORE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>J.</b> Last <b>KEMPF</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>5</b> Year <b>1959</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</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>APR 26 1907</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>		11. BIRTHPLACE (City and state or country) <b>PILOT GROVE, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>HENRY KEMPF</b>			13b. MOTHER'S MAIDEN NAME <b>ROSE STRETZ</b>			14. NAME OF HUSBAND OR WIFE <b>MARGARET KEMPF</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>496-01-0735</b>		17. INFORMANT <b>MARGARET KEMPF, 3341 BALTIMORE</b> Address		
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>UREMIA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Bilateral Ureteral Obstruction</b> DUE TO (c) <b>Metastatic Carcinoma of Bladder</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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 <b>1954</b> to <b>7-5-59</b> and last saw her/him alive on <b>7/4/59</b> Death occurred at <b>11:00</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Leo F. Cooper M.D.</b> (Degree or title)				22b. ADDRESS <b>1220 E. 31st R.C. 9, MO</b>		22c. DATE SIGNED <b>7-7-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JULY 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET Cemetery</b>		23d. LOCATION (City, town, or county) <b>KANSAS CITY MISSOURI</b>		(State)	
24. FUNERAL DIRECTOR <b>MUEHLEBACH</b> ADDRESS <b>6800 TROOST</b>			25. DATE RECD. BY LOCAL REG. <b>7-7-59</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Leo F. Cooper**

Dr Leo ...  
1220 E 31  
WE 1-6951  
11:30 - 2:30

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. T. Crowell

Licensed Embalmer No. 4904  
P. O. Address H. C. Me

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.