

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026830

STATE FILE NUMBER
2 6033
REGISTRATION DISTRICT NO. 2

FILED JUL 17 1959

Registration District No. Primary Registration District No.

300
-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Claytonis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>4432</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp	Length of stay in 1b.	d. STREET ADDRESS (If outside, give location) #4 Tuscany Park	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LOUISE Middle CHAPIN Last KEMP	4. DATE OF DEATH Month June Day 24 Year 1959
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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 Nov 11, 1886	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR HOUSEwife	11. BIRTHPLACE (City and state or country) Jacksonville, Florida	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Duncan U. Fletcher	13b. MOTHER'S MAIDEN NAME Ella Louise Paine	14. NAME OF HUSBAND OR WIFE Dr. Thomas J. Kemp
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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) no	16. SOCIAL SECURITY NO.	17. INFORMANT (late) Mrs. Smith Gordon Address 412 S. Union Blvd
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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) <i>Pulmonary embolism massive</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Postleukemia</i> DUE TO (c) <i>Generalized osteoarthritis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>350 x</i>	INTERVAL BETWEEN ONSET AND DEATH <i>instant</i> <i>4-5 year</i> <i>4-5 year</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from <i>6/21/59</i> to <i>6/25/59</i> and last saw her alive on <i>6/25/59</i> Death occurred at <i>10:30 A.M.</i> m 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) <i>James C. Wood M.D.</i>	22b. ADDRESS <i>35 North Central</i>	22c. DATE SIGNED <i>6/25/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>6/26/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Jacksonville, florida</i>
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24. FUNERAL DIRECTOR <i>C. R. Lupton and sons</i>	ADDRESS <i>7233 Delmar</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 26 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D. MAB</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

GET REMOVAL PERMIT BY RAIL
2 to 5 P.M.
*Dr. Woods (Dr. Brown County)

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 Clarence A. Murr

Licensed Embalmer No. 4011
P. O. Address St. Louis, 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.