

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039321**

FILED VS. DEC. 2 1959 69

Primary Registration District No. 4120 Registrar's No. 14

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Christian</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cleaver</u>		Length of stay in lb <u>6 yrs.</u>		c. CITY OR TOWN <u>Cleaver</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) _____		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>Phillip</u> Last <u>Kemp</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> - Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-1872</u>		9. AGE (last birthday) <u>86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13a. FATHER'S NAME <u>John B. Kemp</u>			13b. MOTHER'S MAIDEN NAME <u>---?--- Bolton</u>			14. NAME OF HUSBAND OR WIFE <u>Nettie Kemp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Nettie Kemp--Cleaver, Missouri</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u>									
DUE TO (b) <u>Arteriosclerosis</u>									
DUE TO (c) _____									
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 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 <u>Sept. 23, 1959</u> to <u>Nov. 16, 1959</u> and last saw him on <u>Nov. 16, 1959</u> Death occurred at <u>11:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>B. W. Marshall, D.O.</u>				22b. ADDRESS <u>Billings, Missouri</u>				22c. DATE SIGNED <u>Nov. 21/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-19-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey-Springfield, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 25, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Cline Hutter</u>			

DOCUMENT

MEDICAL CERTIFICATION

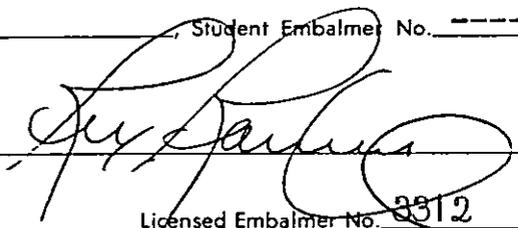
BY AFFIDAVIT OF

**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   
Licensed Embalmer No. 3512

P. O. Address Springfield,

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.