

AMENDED FILED MAR 30 1961 318 Primary Registration District No. 1003 Registrar's No. 2790 STATE FILE NUMBER

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURY</u> COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, Mo.</u>		Length of stay in 1b <u>LIFE</u>		c. CITY OR TOWN <u>ST. LOUIS</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 <u>ST. JOHN HOSP.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3639 GASCONADE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE H. HEMPEN</u>				4. DATE OF DEATH Month Day Year <u>3-21-61</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>9-3-1885</u>		9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. U.</u>					
13a. FATHER'S NAME <u>Anton Hempen</u>				13b. MOTHER'S MARDEN NAME <u>Basena Shaper</u>				14. NAME OF HUSBAND OR WIFE <u>Elizabeth Nekenberg Hempen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Elizabeth M Hempen 3639 Gasconade</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 Arteriosclerosis Thrombosis</u>										<u>6 days</u>			
DUE TO (b) <u>Cerebral Arteriosclerosis</u>										<u>5 yrs</u>			
DUE TO (c) <u>332x</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Emphysema</u>										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 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.)									
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>1956</u> to <u>3-21-61</u> and last saw him alive on <u>3-20-61</u> Death occurred at <u>4:10 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Wm F. Kirtner M.D.</u>				22b. ADDRESS <u>950 Francis St.</u>				22c. DATE SIGNED <u>3-23-61</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Ann</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>							
24. FUNERAL DIRECTOR <u>Wm F. Kirtner</u>				ADDRESS <u>3819 So Grand Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 23 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>					

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 _____
Leo J. Kimbermedle

Licensed Embalmer No. 4611
P. O. Address St. Louis 18 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.