

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024808

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. Wakeman

Registration District No. 128

Primary Registration District No.

Registrar's No. 682

STATE FILE NUMBER

FILED JUL 24 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ROGERSVILLE		Length of stay in 1b 63 YRS.	c. CITY OR TOWN ROGERSVILLE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ROUTE # 2		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE # 2
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES KEMMLING			4. DATE OF DEATH Month Day Year JULY 19 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/29/75	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME HENRY KEMMLING		13b. MOTHER'S MAIDEN NAME FRANCES SCHOCH		14. NAME OF HUSBAND OR WIFE RUBY KEMMLING		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			17. INFORMANT Address RUBY KEMMLING, RT # 2 ROGERSVILLE, MO.			

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>Melanotic Carcinoma of Lung, Larynx, Urteral Spine, Scapula</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Carcinoma Prostate, Urinary Bladder</i>	
	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	
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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 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
21. I attended the deceased from <i>May 1961</i> to <i>7-19-61</i> and last saw her/him alive on <i>7-4-61</i> Death occurred at <i>6 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE (Degree or title) <i>J. N. Wakeman M.D.</i>		22b. ADDRESS <i>Springfield, Mo.</i>		22c. DATE SIGNED <i>7-20-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>7/22/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>HAZELWOOD</i>		23d. LOCATION (City, town, or county) (State) <i>SPRINGFIELD, MO.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</i>		25. DATE RECD. BY LOCAL REG. <i>7-20-61</i>	26. REGISTRAR'S SIGNATURE <i>Effie S. Mellon</i>		

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

AUG 8 1961

NOV 3 5 1961

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 ALMOR Owen

Licensed Embalmer No. 2727

P. O. Address ALMOR Owen

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.