MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

153

1. PLACE OF DEATH
County Boone — Registration District No. 79 — File No. 2
Township Burbon — Primary Registration District No. 5116 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Chas G Kimmel
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

FEB 18

10

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 26 1865

7. AGE — YEARS 66 — MONTHS 4 — DAYS 16 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Chas Kimmel
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Louise Sturgeitz
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Myron Kimmel
(Address) Flint Mich

15. FILED 1/12/ 1936. E. N. Lentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1929, to Jan 11 1930 that I last saw him alive on Jan 7 1930, and that death occurred, on the date stated above, at 4 30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency
97H
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) .....
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? NO DATE OF .....
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs
(Signed) A. R. McCormack, M. D
, 19 (Address) Sturgeon Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Joseph, Mo — DATE OF BURIAL 1-14 1930

20. UNDERTAKER Barner Furniture & Co — ADDRESS Sturgeon Mo

...em of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...EATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

64 - 4 - 15

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Boone — Registration District No. 79 — File No.

Township Bourbon — Primary Registration District No. 5116 — Registered No. 2

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Chas G. Kimmel

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 26-1865

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
64	4	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 1/12/1930 E. N. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every ... of information should be carefully ... should be stated EXACTLY. PHYSICIAN ... CAUSE OF DE... in plain terms, so that it may be ... ified. Exact statement of OCCUPATION is ... REGI... T RECEIVE A FEE FOR CERTI... UNTIL THEY ARE COMPLETE AS PRESCRIB...

S-153