

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JUL 12 1940

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

21238
Do not use this space.

1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township St. Joseph Primary Registration District No. 1001
 (c) City Missouri (d) Street No. State Hospital #2. Registered No. 643
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred 32 yrs. 10 mos. 7 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MOLLIE STIMBORO

(a) Residence, No. State Hospital #2., St. Joseph, Missouri (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June

7. AGE YEARS 80 MONTHS ? DAYS ? If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Houskeeper

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nebraska

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT State Hospital Records (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Kirksville, Mo. DATE June 10, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Summers and Flinchbaugh
Kirksville, Mo.

20. FILED 6/11/40 19 6/11/40 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 10, 1940

22. I HEREBY CERTIFY, That I attended deceased from 7/1/39, 19, to 6/10/40, 19.

I last saw h. ar. alive on June 9, 19 40 Death is said to have occurred on the date stated above, at 7:45 a. m.

The principal cause of death and related causes of importance were as follows:
Bronchopneumonia Date of onset 6/3/40

Other contributory causes of importance:
Tuberculosis of the lungs

Name of operation _____ Date of _____

What test confirmed diagnosis? CLINICAL Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? NO Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO
 If so, specify _____
 (Signed) W. J. D'el, M. D.
85 (Address) St. Joseph

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.....

E. T. Whitaker....., Registered Apprentice No.....
working under my personal supervision.

Signed *W. C. Summers*.....

Licensed Embalmer No. *2159*.....

P. O. Address *Kershville, N.C.*.....

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 this body is not embalmed, above space should be left blank.