

FILED OCT 18 1940

Registration District No. 400

Primary Registration District No. 555312

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Pural Prairie  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2  
(Specify whether)

In this community 54 yrs  
years, months or days

3. (a) PRINT FULL NAME Winfield Scott Kimmurman

3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex Male 5. Color of hair white

6. (a) Name of husband or wife Eliza Kimmurman 6. (c) Age of husband or wife if alive 6 years

7. Birth date of deceased July 6th 1855  
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 6 If less than one day hr. min.

9. Birthplace Cataract Falls Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER  
12. Name Wm S Kimmurman  
13. Birthplace West Morland Co. Pa.  
14. Maiden name Burieda Smith  
15. Birthplace unknown Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Kimmurman  
(b) Address Pural Prairie Mo.

17. (a) Burial (b) Date thereof Sept 24-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cherant Hill Cem.

18. (a) Signature of funeral director Fields Funeral Home  
(b) Address Pural Prairie Mo.

19. (a) 9-23-40 (b) Sam H. Cannon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Pural  
(If outside city or town limits, write "RURAL")

(d) Street No. Residence  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22  
year 1940 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 19 1938 to 9-22 1940  
that I last saw him alive on Sept 21 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration ?

Due to 93C

Due to Pyelitis & Cystitis 2 Mo.

Other conditions Pyelitis & Cystitis 2 Mo.  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? 932 (Specify type of place)  
(f) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 1 Mo  
Address Pural Prairie Date signed 9/23/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_ *R. C. Fields*

Licensed Embalmer No. *2759*

P. O. Address \_\_\_\_\_

**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.**