

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.

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

22571
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 224
 (b) Township St. Francois Primary Registration District No. 4465
 (c) City Flat River (d) Street No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Reuben Frederick Kimberlain
 (a) Residence, No. _____ St. (If nonresident, give city or town and State) 8
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX mc 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) ✓
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 20 1871
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 2 14
 OCCUPATION 8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. Labour
 9. Industry or business in which work was done, as saw mill, bank, etc. add job
 10. Date deceased last worked at this occupation (month and year) 5-4-41 11. Total time (years) spent in this occupation 70
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co. Mo.
 FATHER 13. NAME Joseph Kimberlain
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co. Mo.
 MOTHER 15. MAIDEN NAME Martha Peters
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pilot Knob Mo.
 17. INFORMANT (ADDRESS) Marvin Kimberlain Flat River Mo.
 18. BURIAL, CREMATION, OR REMOVAL Wood Jew DATE 5-6 41
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Goodwell Bur Flat River Mo.
 20. FILED 5/4 1941 B. B. Besser Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-4 41
 22. I HEREBY CERTIFY, That I attended deceased from Feb 28, 199, to 5-4, 1941
 last saw him alive on 5-3, 1941. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Chr mypoeitis
Hypertension
 Date of onset _____
 Other contributory causes of importance:
none
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Exam Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ 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) C. B. Besser, M. D.
 (Address) Flat River MO

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.....

Licensed Embalmer No.....

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.

Registration District No. 174

Primary Registration District No. 4465

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town _____
(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 _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) St. Francois
(c) City or town Flat River
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Reuben F. Kimberlain

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, wife or child _____

7. Birth date of deceased _____ (Month) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ (less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
18. Birthplace _____ (City, town, or county) _____ (State or foreign country)

{ 14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 5-4-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month _____ day _____
yes _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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.

S-22571

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.....

Licensed Embalmer No.....

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.)

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