

FILLED OCT 9 1941

State File No. _____

Registration District No. 318 822, Primary Registration District No. 5446 Registrar's No. 13

1. PLACE OF DEATH: **GREENE**
 (a) County _____
 (b) City or town FAIR GROVE Franklin
 (c) Name of hospital or institution: R # 2
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution 2
 (Specify whether _____)
 In this community 30 years
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Greene 39
 (c) City or town Fair Grove
 (d) Street No. R.F.D. # 2
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME RACHEL KIMBLE
 3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
 20. DATE OF DEATH, Month Sept day 21
 year 1941 hour 7 minute 30 P. M.
 21. I hereby certify that I attended the deceased from _____ to _____
 that I last saw her dead Sept 22 1941
 and that death occurred on the date and hour stated above.

4. Sex FEMALE
 5. Color of race WHITE
 6. (a) Single, widowed, married, divorced WIDOW
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive 3 years (Day) (Year)
 7. Birth date of deceased Feb 3 1871
 (Month) (Day) (Year)

Immediate cause of death - Slight Stroke
 Duration _____
 Due to Cancerous condition of stomach and bowels
 Due to leptely hemorrhages

8. AGE: Years 70 Months 7 Days 18
 If less than one day hr. min.

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: None
 Of operations _____
 Of autopsy None

9. Birthplace West Virginia
 (City, town, or county) (State or foreign country)
 10. Usual occupation House wife
 11. Industry or business House work in home
 12. Name Wesley Poling
 13. Birthplace West Virginia
 (City, town, or county) (State or foreign country)
 14. Maiden name Corral Stevens
 15. Birthplace West Virginia
 (City, town, or county) (State or foreign country)
 16. (a) Informant Roma Kimble
 (b) Address Springfield Mo.
 17. (a) Burial (b) Date thereof Sept 24-1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Green Lawn Cem
 18. (a) Signature of funeral director W. Wagner
 (b) Address Springfield Mo.
 19. (a) Sept 24 1941 (b) Dallan Barnes
 (Date received local registrar) (Registrar's signature)

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? (a) Means of injury _____
 23. Signature Jas. B. Benton acting Coroner
 (M.D. or other) _____
 Address 1622 1/2 No. Dutton signed 9/24/41

24 (Licensed Embalmer's Statement on Reverse Side) Springfield, Missouri

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

39
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RECEIVED

Greene County Health Office,

County File Number 41-10-98

Date Filed 10/6/41

independent

2000 02

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 *Ogle Sloan Jr.*

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31546

Registration District No. 22

Primary Registration District No. 5446

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Franklin
(If outside city or town limits, write "RURAL" and name of township)
(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)

3. (a) PRINT FULL NAME Rachel Kimble

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 3 1871
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER
12. Name _____
13. 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 _____
(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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I have seen him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death slight stroke Duration _____

Due to Cancerous condition of stomach & bowels
Due to likely Hemorrhage
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?
While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

720
SUPPLEMENTARY

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

S-31546 1941