

5-17-39
X21492
FILLED NOV 17 1941

Registration District No. **1941**

Primary Registration District No. **5399**

Registrar's No. **52**

1. PLACE OF DEATH:

(a) County **Knox**
(b) City or town **Edina Bee Ridge Twp. (Rural)**
(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
In this community **70 yrs: 1** (Specify whether years, months or days)

8. (a) PRINT FULL NAME **Frank Kimball**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **2**

6. (b) Name of husband or wife **Josephine C. Lindsey** 6. (c) Age of husband or wife if alive **7** years

7. Birth date of deceased **1 7 1853**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 8 27 hr. min.

9. Birthplace **Alleganhey N. Y.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **9**

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

14. Maiden name **9**

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

16. (a) Informant **Records of Social Security**

(b) Address **Office - Edina**

17. (a) **Buried** (b) Date thereof **10 5 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Harmony Cemetery**

18. (a) Signature of funeral director **Keith Hudson**

(b) Address **Edina, Missouri**

19. (a) **Oct 11 1941** (b) **Mr. C.M. Smith**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Knox**
(c) City or town **Edina Bee Ridge Twp.**
(If outside city or town limit, write "RURAL")
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **4**
year **1941** hour **5 A.M.** minute **0** A.M.

21. I hereby certify that I attended the deceased from **Oct 2nd** 1941 to **Oct 4** 1941 that I last saw him alive on **Oct 4** 1941 and that death occurred on the date and hour stated above.

Immediate cause of death **Cholelithiasis**

Due to **Cholelithiasis** Duration **3 days**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **126**

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) (e) Means of injury

23. Signature **C. Hudson** (Name of other)
Address **Edina, Mo.** Date signed **10-4-41**

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

502

052000

RECEIVED

District Health Officer No. 10

District File Number 11-41-2082

Date Filed NOV 15 1941

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Minn.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35320
Registrar's No.

Registration District No. 411

Primary Registration District No. 5599

1. PLACE OF DEATH:

(a) County Knox
(b) City or town Rural
(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 years, months or days)

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 _____

3. (a) PRINT FULL NAME Frank Kimball

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 w

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

7. Birth date of deceased Jan 7
(Month) (Day) (Year)

8. AGE: Years 88 Months 8 Days _____
(If less than one day, in min.)

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

10. Usual occupation _____

11. Industry of 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) Dec 1941 (b) Mrs C.M. Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Oct year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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? _____

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

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

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

SUPPLEMENTARY

undertaker accepted me as informant
social security office
no more available

S-35320