

FILED APR 22 1942

Registration District No. 478499

Primary Registration District No. 4267

1. PLACE OF DEATH:

(a) County LACLEDE
 (b) City or town LEBANON MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
WALLACE HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 DAYS
 (Specify whether
 In this community 30 YRS
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE
 (c) City or town RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No. P.O. Box 76, LEBANON MO
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 31
 year 1942 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from
3-17-42 19, to 3-31-42 19;
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis ✓
 Duration _____

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)
hypertension

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 J. A. M. Corcoran (M. D. or other):
 Address _____ Date signed _____

3. (a) PRINT FULL NAME MINNIE EVA 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 SINGLE

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

7. Birth date of deceased MAR 28 1878
 (Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days 3 If less than one day _____ hr. _____ min.

9. Birthplace ADAIR CO MO
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name CHAS T. KIMBLE

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

14. Maiden name MARY S. MILLER

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

16. (a) Informant Mrs Frank Kimble

(b) Address Lebanon Mo

17. (a) BURIAL (b) Date thereof 4-1-42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) April 1-42 (b) Isaac Roper
 (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. -----
District File Number 4-42-76 -----
Date Filed April 16, 1942 -----

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

ALLEN DETHERAGE, Registered Apprentice No. 294
working under my personal supervision.

Signed [Signature]

Licensed Embalmer No. 1161

P. O. Address LEBANON Mo.

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. 11 142
Registrar's No.

Registration District No. 449

Primary Registration District No. 4267

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(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 Minnie E. 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 S
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased mar 28 1878
(Month) (Day) (Year)

8. AGE: Years 64 Months - 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..... (Month) (Day) (Year)
(Burial, cremation, or removal) (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 mar Day 28 year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Duration

acute nephritis
Due to.....
Due to not chronic nor sequelae of anything
Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations..... 130
Of autopsy.....
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.....

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

SUPPLEMENTARY

S-11142 1942