

FILED MAY 12 1942 99

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of locality)

(c) Name of hospital or institution: St. Mary's
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 3242 Roberts
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? ✓ years.

3. (a) PRINT FULL NAME Dollie Mae Kimble

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Fe 5. Color or race wh 6. (a) Single, widowed, married divorced 1

6. (b) Name of husband or wife Louis M. Kimble 6. (c) Age of husband or wife if 53 years

7. Birth date of deceased Aug. 18 1885
(Month) (Day) (Year)

8. AGE: Years 56 Months 8 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Edward Sheldon

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

14. Maiden name unknown

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

16. (a) Informant Louis M. Kimble

(b) Address 3242 Roberts

17. (a) Burial (b) Date thereof 4-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills

18. (a) Signature of funeral director Frank Masterson

(b) Address 5811 Traver

19. (a) 4-23-42 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21 year 1942 hour _____ minute A M.

21. I hereby certify that I attended the deceased from 4-8-42, 19____, to 4-21-42, 19____; that I last saw her alive on 4-21-42, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Pulmonary artery thrombosis of the heart

Due to gangrenous appendicitis

Due to thrombosis of the heart

Duration 4 1/2

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Major findings Of operations See above

Of autopsy See above

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? _____

23. Signature M. M. Crow (Specify type of place) _____
(M. D. or other) (M. D.) (If Mechanic of injury)

Address 1034 Oak Hill Rd. N. P. Mo. Date signed 4-23-42

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

MOTHER FATHER

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 Ray Buffington
Licensed Embalmer No. 2756
P. O. Address K. Q. 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.