

BUREAU OF THE CENSUS  
FILED AUG 13 1942

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph State Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 Mos. 5 ds.  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 311 So. 15th  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Robert Kimmel

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Sept. 15 1873  
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Joseph, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name No. 13th  
13. Birthplace Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Mo.  
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alice Kimmel

(b) Address 311 S. 15th, St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-1942  
(Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery  
St. Joseph, Mo.

18. (a) Signature of funeral director Hector Meierhoffer  
(b) Address 13th. & Feraon St., St. Joseph, Mo.

19. (a) 7-18-42 (Date received local registrar) (b) Rae Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th  
year 1942 hour 4:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 3-12-1942 to 7-17-1942  
and that death occurred on the date and hour stated above.

that I last saw him alive on 7-17-1942

Immediate cause of death Broncho-pneumonia-bilateral (terminal)

Due to Chronic-pulmonary tuberculosis

Due to \_\_\_\_\_

Other conditions Markedly emaciated  
(Include pregnancy within 3 months of death)

Major findings: 1381  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature J. G. Dell (M. D. or other) \_\_\_\_\_  
Address St. Joseph Date signed 7/18/42

Duration

2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

#P

**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.

*Not Embalmed*

Signed

*Geo E Daniel*

Licensed Embalmer No.

*3300*

P. O. Address

*St Joseph 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.**