27296

S. No. 9-4-41 5-17-39 I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 14 1942

Registration District No. 384141 Primary Registration District No. 42273025 Registrar's No. 46

46

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

**1. PLACE OF DEATH:**

(a) County HOWELL

(b) City or town WEST PLAINS, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 12 Langston St. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No. (Specify whether

In this community 50 years. years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County HOWELL 46

(c) City or town WEST PLAINS, (If outside city or town limits, write "RURAL") 1

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME CHARLES EDWARD KIMBERLIN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife Mary A. Kimberlin

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

7. Birth date of deceased SEPTEMBER (Month) 29, (Day) 1866 (Year)

8. AGE: Years 75 Months 6 Days 26 If less than one day hr. min.

9. Birthplace STEELEVILLE, (City, town, or county) MISSOURI 0 (State or foreign country)

10. Usual occupation Real Estate Dealer

11. Industry or business Own.

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant Mrs. Leland Rothgeb

(b) Address WEST PLAINS, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 26, 1942 (Month) (Day) (Year)

Oak Lawn Cem.

(c) Place: burial or cremation WEST PLAINS, Mo.

18. (a) Signature of funeral director Hal Thornburgh

(b) Address WEST PLAINS, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month APRIL day 25, year 1942 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 4-8-, 1941, to 4-25-, 1942 that I last saw him alive on 4-24-, 1942 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | |
| Due to General Arteriosclerosis | |
| Due to | |
| Other conditions Chronic Prostatic Hypertrophy (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

13 Na

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. C. Bohrer (M. D. or other) MD

Address West Plains, Mo. Date signed 5-3-42

11 20

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 942774
Date Filed 9-11-42

## 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 Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Palmyra, Va.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 27296

Registration District No. 141 Primary Registration District No. 3025 — Registrar's No.

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

**1. PLACE OF DEATH:**

(a) County: Howell

(b) City or town: West Plains
(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)

In this community

**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: Charles E Kimberlin

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: Sept (Month) 29 (Day) 1866 (Year)

8. AGE: Years 75 Months 6 Days 29 If less than one day hr. min.

9. Birthplace: Mo (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5-5-42 (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April Day 25 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw him alive on 19;

and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY 25