

No. 2
-5-42
-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7792

FILED MAR 8 1943
6087

State File No.
Registrar's No. 5

Registration District No. Primary Registration District No. 3071

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Slater
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
In this community all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline
(c) City or town Slater
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Hiram Rimbey
3. (b) If veteran, name war none
3. (c) Social Security No. 709-12-1467

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 7th
year 1943 hour 4 minute 30 A.M.

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife none
6. (c) Age of husband or wife if alive V years
7. Birth date of deceased Nov. 26 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 1942 to Feb-7-1943
that I last saw him alive on Feb-7-1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
73 2 11 hr. min.

Immediate cause of death
Cerebral Apoplexy
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
JBC

9. Birthplace Cambridge, Mo. O
(City, town, or county) (State or foreign country)
10. Usual occupation R.R. bridge carpenter

PHYSICIAN
Underline the cause to which death should be charged statistically.
Major findings:
Of operations
Of autopsy

MOTHER FATHER
11. Industry or business
12. Name Benjamin Rimbey Pa. /
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name Marguerite Jackson
15. Birthplace Saline Co. Mo. O
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Grace Rimbey Slater, Mo.
(b) Address burial
17. (a) (Burial, cremation, or removal) (b) Date thereof 2-9-1943
(Month) (Day) (Year)
(c) Place: burial or cremation Slater, Mo.
18. (a) Signature of funeral director Hill Brothers
(b) Address Slater, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

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) (c) Means of injury
23. Signature M.P. Suggins (M. D. or other)
Address Slater, Mo. Date signed 2-8-43

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-5-43

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 _____

Licensed Embalmer No. 1292

P. O. Address St. Louis 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. 7792

Registration District No. 6097

Primary Registration District No. 3071

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Slater
(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 _____ Life
years, months or days)

3. (a) PRINT FULL NAME James H. Rimbey

3. (b) If veteran, name war _____ 3. (c) Social Security No. 709-13-1467

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: Nov 26 (Month) (Day) (Year)

8. AGE: Years 73 Months 2 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) _____ (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) Feb 26-43 (b) Mrs. John Giger (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Slater
(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 Feb day 26 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ 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 _____

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

