

FILED JUN 23 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19908

State File No.

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5494

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis,  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Congress Hotel,  
 (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 Life time \_\_\_\_\_  
 (Specify whether years, months or days) \_\_\_\_\_

3. (a) PRINT FULL NAME May Blossom Kimber,

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Thomas C. Kimber, 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased September 28, 1861  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>19</u>	hr. _____ min.

9. Birthplace St. Louis, Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Henry M. Blossom,  
 13. Birthplace New York,  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Susan Brigham,  
 15. Birthplace New York,  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. THos. T. Richards.  
 (b) Address 5272 Washington Ave.,  
 (c) Place: burial or cremation Bellefontaine Cem.  
 (d) Date thereof 6/19/44  
 (Month) (Day) (Year)

18. (a) Signature of funeral director Wagoner Mortuary  
 (b) Address JUN 18 1944 Lindell Blvd.  
 19. (a) (Date received local registrar) \_\_\_\_\_ (b) J. F. Busch  
 (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis,  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 275 Union Ave.,  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17  
 year 1944 hour 8 minute 45 M. A.

21. I hereby certify that I attended the deceased from August  
 \_\_\_\_\_, 1943, to June 17, 1944  
 that I last saw him alive on July 24, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Duration \_\_\_\_\_

Due to Osteomyelitis

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?

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

23. Signature L. H. Hausman (M. D. or other) \_\_\_\_\_  
 Address 203 Business Bldg Date signed 6/17/44

Alf Hempelman  
3720 Washington

APR 27 1948

**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

*Neville B. Frohwith*

Licensed Embalmer No.

*3696*

P. O. Address

*4161 Seidell*

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

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