S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27062

State File No.

Registration District No. 1

Primary Registration District No. 5003

Registrar's No. 215

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural Morrow Twp. (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair

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

(d) Street No. near Green Castle (If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME Margaret Leanna Kimberly

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife John Kimberly

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

7. Birth date of deceased 9 (Month) 11 (Day) 1865 (Year)

8. AGE: Years 78 Months 11 Days 00 If less than one day hr. min.

9. Birthplace Ind (City, town, or county) Indiana (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Bryant Anderson
13. Birthplace (City, town, or county) Ind (State or foreign country)

MOTHER
14. Maiden name Ann Dupree
15. Birthplace (City, town, or county) Ind (State or foreign country)

16. (a) Informant Raymond Kimberly

(b) Address Green Castle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle

18. (a) Signature of funeral director Glenn E. Kent & Son

(b) Address Green City Mo.

19. (a) 8-16-44 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11 year 1944 hour 8:00 minute P M.

21. I hereby certify that I attended the deceased from Aug 9, 1944, to Aug. 11, 1944 that I last saw her alive on Aug 9, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions (Include pregnancy within 3 months of death) 830

Major findings:
Of operations

Of autopsy

Duration

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 [illegible] (M.D. or other)

Address Sheridan Mo. Date signed 8-14-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-44-1520
Date Filed SEP 7 1944

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.