

Registration District No. _____ Primary Registration District No. _____

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:
St. Louis Children's Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Illinois (b) County Madison
 (c) City or town Granite City
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? 9 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James Harvey Kimbro
 3. (b) If veteran, name war Nil
 3. (c) Social Security No. None

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased October 15 1932
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>12</u>	<u>6</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace Madison Illinois
(City, town, or county) (State or foreign country)
 10. Usual occupation Student

MOTHER FATHER
 11. Industry or business _____
 12. Name Joseph Kimbro
 13. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)
 14. Maiden name Grace Barnes
 15. Birthplace Unknown Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Kimbro
 (b) Address Granite City, Ill.
 17. (a) Removal (b) Date thereof 4-23-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Granite City, Ill.

18. (a) Signature of funeral director Albert H. Hoppe, Inc.
 (b) Address 4700 Washington Blvd.
APR 23 1945
 19. (a) (Date received local registrar) (b) J. J. Brebeck
(Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 21
 year 1945 hour 11 minute 25 AM
 21. I hereby certify that I attended the deceased from 4-19-45
 _____, 19____, to 4-21, 1945
 that I last saw him alive on 4-21, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Encephalitis (Shorea)
 Duration _____

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 [Signature] (M. D. or other) _____
 Address _____ Date signed 4/21

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

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 *Albert G. Hoffe*.....

Licensed Embalmer No. *2971*.....

P. O. Address.....

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.