#40551

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 21 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15281

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 1076

U. S. No. 2
10M—2-43
Rev. 5-17-39
1 X35697

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days (Specify whether years, months or days)

In this community

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. 213 S. 3rd St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME FRANK KIMBLE

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased December (Month) 9 (Day) 1866 (Year)

8. AGE: Years 78 Months 4 Days 23 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name John Kimble

13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

14. Maiden name Annie Rose Unknown

15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant John P. Cullinane

(b) Address Public Administrator

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-5-45 (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEMETERY

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 8 1945 (Date received local registrar) J. F. Budack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1945 hour 3:45 minute A. M.

21. I hereby certify that I attended the deceased from 4/9/45, 19, to 5/2/45, 19; that I last saw him alive on 5/2/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach with metastasis

Due to

Due to

Other conditions Secondary anemia
(Include pregnancy within 3 months of death)

Major findings: Of operations Same 3 yrs ago

Of autopsy None performed

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?

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

23. Signature Geo Gebhardt (M. D. or other)

Address 1515 Lafayette Date signed 5/2/45

(Licensed Embalmer's Statement on Reverse Side)

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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 L. Hoffer

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.