

FILED AUG 14 1945

Registration District No. **183**

Primary Registration District No. **5685**

Registrar's No. **17**

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

1. PLACE OF DEATH

(a) County **Linn**

(b) City or town **Purdin, Rural - Jackson**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME **JOHN W KIMBROUGH**

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex **Male (M)** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased **July 9 1956**
(Month) (Day) (Year)

8. AGE: Years **89** Months **0** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **Sullivan Co. mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Thomas Kimbrough**

13. Birthplace **North Carolina** (City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Moore**

15. Birthplace **Virginia** (City, town, or county) (State or foreign country)

16. (a) Informant **Reubah Palmer**

(b) Address **Purdin mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **July 17 48** (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Olive, cem**

18. (a) Signature of funeral director **E. J. Robertson**

(b) Address **Lare do. mo**

19. (a) **July 17 1945** (Date received local registrar) (b) **Mrs E C Woolf** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn 58**

(c) City or town **Purdin Rural** (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 **July** day **15** year **1945** hour **5:30** minute **7** P. M.

21. I hereby certify that I attended the deceased from **July 11** 19 **45** and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory shock**

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)

(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 **W. H. Munroe** (M. D. or other) _____

Address **Whiting mo** Date signed **July 17 45**

PHYSICIAN

Duration _____

Underline the cause to which death should be charged statistically.

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 John M Robertson
Licensed Embalmer No. 4388
P. O. Address Laredo 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.