S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED SEP 11 1945

State File No. 26793

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 221

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 202 N Garth 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community all her life 2 years, months or days) 69 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone 10

(c) City or town Columbia 2 (If outside city or town limits, write "RURAL")

(d) Street No. 202 N. Garth Ave 4 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Maggie W Kimbrough

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F. 3

5. Color or race Colored

6. (a) ~~Single~~, ~~widowed~~, married, ~~divorced~~ 1

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. (Month) 17 (Day) 76 ~~45~~ (Year)

8. AGE: Years 69 Months Days If less than one day hr. min.

9. Birthplace Boone Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Pilot Woods
13. Birthplace Boone Co (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Mary W. Diggs
15. Birthplace Boone Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Emmett Kimbrough

(b) Address 202 N. Garth Ave Columbia

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 16 (Day) 45 (Year)

(c) Place: burial or cremation Columbia Cem

18. (a) Signature of funeral director A. C. Freeman

(b) Address 608 Park Ave. Columbia Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 14 year 45 hour 9 minute 20 M.

21. I hereby certify that I attended the deceased from May 15, 19 , to Aug 14, 1945, that I last saw her alive on Aug 13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer Paralysis of lower limbs

Due to Bladder & bowels Nephritis Acute

Due to Cause unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 46
Of autopsy yes

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) no

(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 Stephen Dlewski (M. D. or other)

Address Columbia Date signed 8/16/45

1425

(Licensed Embalmer's Statement on Reverse Side)

SEP 25 1945

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 Me

, Registered Apprentice No.

working under my personal supervision.

Signed A. C. Freeman

Licensed Embalmer No. 2837

P. O. Address 608 Park Ave Columbia

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, above space should be left blank.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 28 Primary Registration District No. 3006 Registrar's No. 221

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME Maggie W. Kimbrough

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 17 (Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 22 Unless less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Aug 16 1945) (Date received local registrar) (b) Mrs R E Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 14 Day
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death — 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S- 26793