No. 2
8-13
17-39
X37823

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

37843

State File No. 40

FILED DEC 13 1945

Registration District No. 188 Primary Registration District No. 0699 Registrar's No.

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution: None (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 67 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

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

(d) Street No. None (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John West Kimber

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Margaret E. Kimber

6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased January (Month) 19 (Day) 1866 (Year)

8. AGE: Years 79 Months 10 Days 11 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Tom Kimber

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

14. Maiden name Unknown

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

16. (a) Informant T. E. Kimber

(b) Address Avalon, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation Avalon Cemetery

18. (a) Signature of funeral director Norman Funeral Home

(b) Address Chillicothe, Missouri

19. (a) Dec 2 (Date received local registrar) (b) Mrs. Earl Howe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30th year 1945 hour 7 minute 50 a. M.

21. I hereby certify that I attended the deceased from Oct 30 to Nov 30 1945 that I last saw him alive on Nov. 29 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	10 years
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? (Specify) (e) Means of injury

23. Signature (M. D. or other)

Address Chillicothe Mo Date signed Dec 1/45

1540

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number _____
Date Filed _____

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 Elton F. Norman, Registered Apprentice No. _____, working under my personal supervision.

Signed Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.