

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

**FILED DEC 17 1946**  
 Registration District No. 73

Primary Registration District No. 5290

Registrar's No. 89

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

1. PLACE OF DEATH:  
 (a) County Clay  
 (b) City or town Kearney Rural Kearney Twp  
 (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 \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Clay  
 (c) City or town Kearney (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 Kate KIMZIE  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec day 4  
 year 1946 hour 9:50 minute \_\_\_\_\_ P. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Earl Kimzie  
 6. (c) Age of husband or wife if alive 62 years  
 7. Birth date of deceased Sept 27 1873  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 that I last saw \_\_\_\_\_ alive on \_\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Coronary thrombosis Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
72 2 7 hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Coronary  
 Due to \_\_\_\_\_  
 Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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

10. Usual occupation Housekeeper

11. Industry or business Gen House work

12. Name Dudley Ador

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

14. Maiden name Elizabeth Fritch

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

16. (a) Informant Mrs Chester Thompson  
 (b) Address Holt Mo

17. (a) Burial (b) Date thereof Dec 7 - 46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Edward Fry  
 (b) Address Kearney Mo

19. (a) Dec 7, 1946 (b) Minnie Hays  
 (Date received local registrar) (Registrar's signature)

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) Coronary thrombosis  
 (b) Date of occurrence 12-4-46  
 (c) Where did injury occur? Kearney Mo. R.F. D.  
 (City of town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home on farm, 7 mi NW, Kearney Mo.  
 While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature R.W. Prother (M. D. or other) \_\_\_\_\_  
 Address Galena Springs Mo. Date signed 12-5-46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-14-46

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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..... Leonard Fry.....

Licensed Embalmer No..... 1677.....

P. O. Address..... Kearney 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.**