

S. No. 2
M-8-43
5-17-39
P.1 X37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20032**

FILED JUN 26 1947

Registration District No. _____

Primary Registration District No. **4015**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **ATCHISON**
(b) City or town **Rural**
(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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ATCHISON** **3**
(c) City or town **PHELPS CITY**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **WATSON REEP KIMBLE**

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 **SINGLE**

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

7. Birth date of deceased **10 11 1899**
(Month) (Day) (Year)

8. AGE: Years **47** Months **7** Days **23** If less than one day _____ hr. _____ min. **0**

9. Birthplace **PHELPS CITY MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER.**

11. Industry or business **FARM**

12. Name **GEO. KIMBLE**

13. Birthplace **ST. JOSEPH MO**
(City, town, or county) (State or foreign country)

14. Maiden name **DILLON RICHARDSON**

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

16. (a) Informant **Wm. Delahanty**

(b) Address **Rock Pt. Mo**

17. (a) **BURIAL** (b) Date thereof **6-6-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MILLSAP.**

18. (a) Signature of funeral director **BARTHOLOMEW MORTUARY**

(b) Address **Rock Port Mo.**

19. (a) **June 5 1947** (b) **Betty Crabbler**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **4th**
year **1947** hour **10** minute **17** M.

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

Immediate cause of death **ACUTE MYOCARDITIS**

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **93A**
Of operations _____
Of autopsy _____

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? **2**

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

23. Signature **Thos F Fay** (M. D. or other) **MO**
Address **Method** Date signed _____

Coroner

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

MOTHER FATHER

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..... *Greg Burtalonne*

Licensed Embalmer No. *3173*

P. O. Address *Pock Pt. md*

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.