

No. 2  
-5-43  
17-39  
3667

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30277**  
Registrar's No. \_\_\_\_\_

**FILED SEP 23 1947**

Registration District No. 12 Primary Registration District No. 5053

**1. PLACE OF DEATH:**

(a) County Barry

(b) City or town Shell Knob  
(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 Missouri (b) County Barry

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Virgil Kimball

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 Sarah B. Kimball

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

7. Birth date of deceased Novmber 28, 1856  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month August day 31  
year 1947 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Aug 20  
1947, to Aug 31, 1947  
that I last saw him alive on Aug 20, 1947  
and that death occurred on the date and hour stated above.

8. **AGE:**

Years	Months	Days	If less than one day
<u>90</u>	<u>9</u>	<u>3</u>	hr. _____ min. _____

9. Birthplace Fort Des Moines, Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation retired Farmer

Immediate cause of death Arteriosclerosis of Kidney

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 5-2-A  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Frank Kimball

(b) Address Shell Knob, Missouri

17. (a) Burial (b) Date thereof 9-2-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Painter Cemetery

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

(b) Address Cassville, Missouri

19. (a) 1-3-48 (b) Mrs Gene Hudson  
(Date received local registrar) (Registrar's signature)

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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 S. Purvis (M. D. or other) 100  
Address Cassville, Mo Date signed 9-1-47

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.....

*Ruby Elkins*....., Registered Apprentice No. *496*  
working under my personal supervision.

Signed *J. E. Culver*.....

Licensed Embalmer No. *3584*.....

P. O. Address *Cassville*.....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *act*

Registration District No. *12* Primary Registration District No. *5053* Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Bary Shell Knob*

(b) City or town \_\_\_\_\_  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME *Virgil Kimball*

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

5. Color or race *m w*

6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if live \_\_\_\_\_

7. Birth date of deceased *Nov. 28 1891*  
(Month) (Day) (Year)

8. AGE: Years *90* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) *1/3/48* (b) *Mr. H. Hudson*  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year *1947* hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-30277