

S. No. 300
M-10-47
v. 5-17-39
I 3906

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33617
Registrar's No. 31

FILED NOV 3 1948
Registration District No. 18483

Primary Registration District No. 4364

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

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Stella, Mo.
(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 2 yrs
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME Ada Lee Kimbrough

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased January 6 1917
(Month) (Day) (Year)

8. AGE: Years 31 Months 9 Days 19
If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

12. Name E. C. Kimbrough

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

14. Maiden name Mary Gailey

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

16. (a) Informant Mrs E. C. Kimbrough

(b) Address Stella, Mo.

17. (a) Burial (b) Date thereof Oct. 27 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockycomfort, Mo.

18. (a) Signature of funeral director W. M. Jones

(b) Address Wheaton, Mo.

19. (a) 10-27 48 (b) Alpha Dyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Stella, Mo.
(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 October day 25
year 1948 hour 3 minute 24 A.M.

21. I hereby certify that I attended the deceased from 10-22 to 10-25 1948
that I last saw her alive on 10-25 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Epilepsy (Grand Mal)
Due to _____

Due to _____

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

Major findings:
Of operations None

Of autopsy None

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? _____

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

23. Signature [Signature] (M. D. or other) MD
Address Stella, Mo. Date signed 10-27-48

RECEIVED
Newton Co. Health Officer
District Health Officer No. 1148-407
District File Number 11-1-48
Date Filed 11-1-48

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 Wm. M. Jones
Licensed Embalmer No. 3492
P. O. Address Wheaton, 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.