

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19629**
2822

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City			c. LENGTH OF STAY (in this place) 19 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City			d. STREET ADDRESS (If rural, give location) 6915 Agnes
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 6915 Agnes							
3. NAME OF DECEASED (Type or Print) a. (First) Corinne		b. (Middle) A.		c. (Last) Kimmel		4. DATE OF DEATH (Month) (Day) (Year) June 29 1949	
5. SEX Fe.	6. COLOR OR RACE Wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH December 24, 1875		9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY xx		11. BIRTHPLACE (State or foreign country) Irondale, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Calland Arnold		13b. MOTHER'S MAIDEN NAME Nancy J. Beebe		14. NAME OF HUSBAND OR WIFE Singleton Henry Kimmel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) xx (If yes, give war or dates of service) xx		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James C. Arnold 6915 Agnes			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive cerebrovascular Accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Previous Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Colon				INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years 3 years	
19a. DATE OF OPERATION Sept 1947		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Colon		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 1, 1947 , to June 29, 1949 , that I last saw the deceased alive on June 29, 1949 , and that death occurred at 8 27A m. , from the causes and on the date stated above.							
23a. SIGNATURE Walton C. Ingham (Degree or title) MD.				23b. ADDRESS 320 W 47th St KC, Mo		23c. DATE SIGNED 6/30/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE June 30, '49	24c. NAME OF CEMETERY OR CREMATORY Cape Girardeau		24d. LOCATION (City, town, or county) (State) Cape Girardeau Missouri		
DATE REC'D BY LOCAL REG. 6-30-49		REGISTRAR'S SIGNATURE Sheldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Bentley Mortuary		ADDRESS 5811 Troost	

(Licensed Embalmer's Statement on Reverse Side)

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

Walton C. Ingham M. D.
320 W. 47th St., Balcony Bldg.
Room 228

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Guy Buffington

Signed _____

Student Embalmer

Licensed Embalmer No. _____

2756

P. O. Address _____

N. C. 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.