

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 43458

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 347 PRIMARY REG. DIST. NO. 6162 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Stone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY Stone	
b. CITY OR TOWN Reeds Spring	c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Reeds Spring	
d. FULL NAME OF HOSPITAL OR INSTITUTION IN City of Reeds Spring		d. STREET ADDRESS (If rural, give location) None	

3. NAME OF DECEASED (Type or Print) JOHN			4. DATE OF DEATH (Month) (Day) (Year) Dec. 25 1949		
5. SEX Male	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1868 MARCH 5 - 1877	9. AGE (In years last birthday) 81	10. UNDER 1 YEAR Months 9 Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME William W. Kimberling	13b. MOTHER'S MAIDEN NAME America Cox	14. NAME OF HUSBAND OR WIFE Ollie Kimberling
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Ollie Kimberling - Reeds Spring, Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 days 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral Insufficiency and cerebral hemorrhage		
	ANTECEDENT CAUSES (b) Arteriosclerosis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 1, 1949, to Dec. 25, 1949, that I last saw the deceased alive on Dec 25, 1949, and that death occurred at 9 P. M., from the causes and on the date stated above.

23a. SIGNATURE L S Shumate M.D.	(Degree or title)	23b. ADDRESS Reeds Spring Mo	23c. DATE SIGNED 12/26/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Dec 28 - 1949	24c. NAME OF CEMETERY OR CREMATORY Kimberling Cemetery	24d. LOCATION (City, town, or county) Stone Missouri
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DATE REC'D BY LOCAL REG. Dec. 27, 1949	REGISTRAR'S SIGNATURE Lena Murray	25. FUNERAL DIRECTOR'S SIGNATURE W. C. Moss	ADDRESS Reeds Spring Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10.6.6

RECEIVED JAN 9 1950  
District Health Office No. 6,  
District File Number 150-57  
Date Filed 1-11-50

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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~~ \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Hermon M. Surridge \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3072

P. O. Address Marionville, 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.