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FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20580**

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **248**

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|--|--|--|--|
| 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 town) Independence | | c. CITY (If outside corporate limits, write RURAL and give township) Independence | |
| c. LENGTH OF STAY (in this place) 44 yrs | | d. STREET ADDRESS (If rural, give location) 814 W. Maple | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Independence Sanitarium | | | |

| | | | | |
|-------------------------------------|-------------------------|----------------------|-----------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Fleta | b. (Middle) B | c. (Last) KRIMMINGER | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | June 21, 1950 |

| | | | | | | | |
|----------------------|-------------------------------|---|--------------------------------------|---|------------------------|-----------------------|-----------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2 | 8. DATE OF BIRTH May 13, 1878 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months | IF UNDER 4 HRS. Hours | IF UNDER 15 MIN. Min. |
|----------------------|-------------------------------|---|--------------------------------------|---|------------------------|-----------------------|-----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY self employed | 11. BIRTHPLACE (State or foreign country) Lafayette Co., Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
|--|--|---|---|

| | | |
|---|---|--|
| 13a. FATHER'S NAME Daniel L. Gordy | 13b. MOTHER'S MAIDEN NAME Aarah A. Maxwell | 14. NAME OF HUSBAND OR WIFE Dr. C. E. Krimminger (deceased) |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Joan W. Howard | ADDRESS RR 9 K. C. Mo. |
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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. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left ventricular failure | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours |
| | ANTECEDENT CAUSES DUE TO (b) Coronary sclerosis | | |
| | DUE TO (c) Myocardial fibrosis | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or conditions causing death. Fracture of left hip | | | Since June 18, 1950 |

| | | |
|---------------------------------------|---|--|
| 19a. DATE OF OPERATION 6-20-50 | 19b. MAJOR FINDINGS OF OPERATION Fracture of left hip operated, hip nailed | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| | | |
|---|---|---|
| 21a. ACCIDENT (Specify) Accident | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) fall on floor of friends home | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Independence Jackson Mo. |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? she slipped on a sawing which slipped on floor throwing her on her hip. |

22. I hereby certify that I attended the deceased from **July 6, 1950** to **June 21, 1950**, that I last saw the deceased alive on **June 21, 1950**, and that death occurred at **12:10A m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) C. H. Allen M.D. | 23b. ADDRESS First National Bank, Indep., Mo. | 23c. DATE SIGNED 6-23-50 |
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| | | | |
|---|--------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE June 23, 1950 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Washington | 24d. LOCATION (City, town, or county) (State) Kansas City 3, Mo. |
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| DATE REC'D BY LOCAL REG. June 22, 1950 | REGISTRAR'S SIGNATURE James B. ... | 25. FUNERAL DIRECTOR'S SIGNATURE W. B. Carson | ADDRESS Independence, Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 28 RECD

JUL 28 1950

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.

Student
Student Embalmer

Signed.....

Tom D. Markland

Licensed Embalmer No.

4592

P. O. Address.....

Indep. 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.