

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

24920

State File No. _____

3636

 BIRTH MO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 2002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <p align="center">Jackson</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p align="center">Missouri</p> b. COUNTY <p align="center">Jackson</p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center">Kansas City</p>		c. CITY OR TOWN <p align="center">Kansas City</p>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center">Nora-Rae Nursing Home</p>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) <p align="center">3 yrs.</p>		e. STREET ADDRESS (If rural, give location) <p align="center">12 1019 EAST 29 ST. 3438</p>	

3. NAME OF DECEASED (Type or Print) a. (First) <p align="center">John</p>		b. (Middle) <p align="center">C.</p>		c. (Last) <p align="center">Kimbrell</p>		4. DATE OF DEATH (Month) (Day) (Year) <p align="center">July 28 1953</p>			
5. SEX <p align="center">D</p>	6. COLOR OR RACE <p align="center">White</p>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <p align="center">Widowed</p>		8. DATE OF BIRTH <p align="center">OCT. 15, 1859</p>		9. AGE (In years last birthday) <p align="center">93</p>	10. IF UNDER 1 YEAR Months <p align="center">9</p>	10. IF UNDER 12 HRS. Hours <p align="center">93</p>	10. IF UNDER 12 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center">RETIRED</p>		10b. KIND OF BUSINESS OR INDUSTRY <p align="center">RAILROAD</p>		11. BIRTHPLACE (City and State or Foreign Country) <p align="center">unknown 9</p>		12. CITIZEN OF WHAT COUNTRY? <p align="center">—</p>			

13a. FATHER'S NAME <p align="center">GEORGE KIMBRELL</p>		13b. MOTHER'S MAIDEN NAME <p align="center">MARY FIELDS</p>		14. NAME OF HUSBAND OR WIFE <p align="center">REBECCA ANN</p>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p align="center">NO NO</p>		16. SOCIAL SECURITY NO. <p align="center">NONE</p>		17. INFORMANT'S SIGNATURE OR NAME <p align="center">GEORGE KIMBRELL</p>	
				ADDRESS <p align="center">1019-E-29 KCMO</p>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <p align="center">holar pneumonia</p>				INTERVAL BETWEEN ONSET AND DEATH <p align="center">5 days</p>
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <p align="center">DUE TO (b) _____</p>				
		DUE TO (c) _____				
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <p align="center">conclusion of metastasis</p>				<p align="center">4907 H</p>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		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 July 19, 1953 to July 22, 1953 that I last saw the deceased alive on July 22, 1953 and that death occurred at 10:50 P.M. from the causes and on the date stated above.

23a. SIGNATURE <p align="center">Herbert L. Mantz</p>		(Degree or title) <p align="center">MD</p>		23b. ADDRESS <p align="center">618 Proj Bldg.</p>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center">REMOVAL</p>		24b. DATE <p align="center">JULY 24-53</p>		24c. NAME OF CEMETERY OR CREMATORY <p align="center">FOREST LAWN CEM.</p>		24d. LOCATION (City, town, or county) (State) <p align="center">OMAHA NEBRASKA</p>	
DATE REC'D BY LOCAL REG. <p align="center">7-23-53</p>		REGISTRAR'S SIGNATURE <p align="center">Geraldine Smith</p>		25. FUNERAL DIRECTOR'S SIGNATURE <p align="center">D. W. Newcomer's Sons</p>		ADDRESS <p align="center">1331 O.C. K.C. MO</p>	

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

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after 1:00 P.M.

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.....
Signature of Student Embalmer

Signed *Herbert A. Jones*.....

Licensed Embalmer No. *4927*.....

P. O. Address *4125 Road*.....
YE

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.