

FILED SEP 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30665**
4028

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) Kansas City		c. CITY OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 50 yrs.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Hosp.		STREET ADDRESS (If rural, give location) 55 2127 E. 37th St.	
3. NAME OF DECEASED a. (First) BLANCHE (Type or Print)		b. (Middle) LEE	
c. (Last) KIMBALL		4. DATE OF DEATH (Month) (Day) (Year) 8 18 54	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/29/85
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Arrow Rock, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Harriet Jones	
13b. MOTHER'S MAIDEN NAME Dillard Collins		14. NAME OF HUSBAND OR WIFE James Wm. Kimball	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS James W. Kimball-2127 E. 37th-K. C. MO.			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolus INTERVAL BETWEEN ONSET AND DEATH 2 hrs. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) acute gangrene of Gall Bladder 1 week. DUE TO (c) Cholecystitis + Cholelithiasis 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5847	
19a. DATE OF OPERATION 8-3-54		19b. MAJOR FINDINGS OF OPERATION Gangrene of Gall Bladder	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 8-3 , 19 54 , to 8-19 , 19 54 , that I last saw the deceased <input checked="" type="checkbox"/> give on 8-18 , 19 54 and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE OF REGISTRAR (Degree or title) Joseph H. Pruitt, M.D.		23b. ADDRESS 701 E 63.	
23c. DATE SIGNED 8/20/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 8/20/54		24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	
24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody McGilley-Eylar-K. C. MO.	
DATE REC'D BY LOCAL REG. 8-20-54		REGISTRAR'S SIGNATURE Heildine Smith	

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Priddy

12-4

701 E. 63rd

Rm. 211

123150

De 54-1

Hook

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 *Arthur Eugene Hook*

Licensed Embalmer No. *4191*

P. O. Address *K C M*

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.