

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

**39838**

State File No. \_\_\_\_\_

No. 300  
10-48

**FILED DEC 10 1954**

BIRTH NO. 63412-54 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 143

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Scott</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>Parma</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>2 Hours</u>		e. STREET ADDRESS (If rural, give location) <u>Rural Route</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Mo. Delta Community Hospital</u>			

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <u>Martha</u> b. (Middle) <u>Jean</u> c. (Last) <u>Kimbrough</u>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>9</u> <u>24</u> <u>1954</u>		
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>Never Married</u>	<b>8. DATE OF BIRTH</b> <u>9-4-1954</u>	<b>9. AGE</b> (In years last birthday) <u>—</u> Months <u>—</u> Days <u>20</u>	<b>10. IF UNDER 1 YEAR</b> Hours <u>—</u> Min. <u>—</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>Parma, Missouri</u>	
				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	

<b>13a. FATHER'S NAME</b> <u>Loyal Kimbrough</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Lena Elkins</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>-----</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>0</u>	<b>16. SOCIAL SECURITY NO.</b> <u>0</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Mr. Loyal Kimbrough, Parma, Mo.</u>	<b>ADDRESS</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>5 days?</u>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Toxemia</u>		
	<b>ANTECEDENT CAUSES</b> DUE TO (b) <u>A. Bronchiolitis</u> DUE TO (c) <u>—</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <u>Parma, Missouri</u>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>

**22. I hereby certify that I attended the deceased from** 9-24, 1954, to 9-24, 1954, that I last saw the deceased alive on 9/24, 1954, and that death occurred at 6:00 P.m., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> <u>E. D. Urban</u>	(Degree or title) <u>M.D.</u>	<b>23b. ADDRESS</b> <u>914 1/2 Sikeston Mo.</u>	<b>23c. DATE SIGNED</b>
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<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>	<b>24b. DATE</b> <u>9/25/54</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Grove</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>Hallsville Mo.</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>11-30-54</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Martha Hunter</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hill Funeral Home</u>	<b>ADDRESS</b> <u>1745 Sikeston Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 6 1954

DATE RECEIVED \_\_\_\_\_

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1254-249



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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.