

FILED DEC 16 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40337**

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 102

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give township) Fayette	c. LENGTH OF STAY (In this place) 7 months	c. CITY OR TOWN Fayette	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 Wells Conv. Home		STREET ADDRESS (If rural, give location) 401 Morrison St. 045/0	

3. NAME OF DECEASED (Type or Print) a. (First) Guida	b. (Middle) ----	c. (Last) Kimmage	4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 22, 1871	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 2 Days 8	IF UNDER 11 HRS. Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) Howard Co. Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Jonothan R. Gallemore	13b. MOTHER'S MAIDEN NAME Fannie Miller	14. NAME OF HUSBAND OR WIFE Wm. J. Kimmage
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Lilburn Hawkins	ADDRESS Fayette, 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary edema		36 hr
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiovascular renal disease		10 yr
DUE TO (c) DUE TO (c) none		442x	

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE OR HOMICIDE (Specify) Natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, place bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 6:15	21e. INJURY OCCURRED WHILE AT WORK? () NOT WHILE AT WORK ()	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 53, 1953, to Nov 30, 1955, that I last saw the deceased alive on Nov 29, 1955, and that death occurred at 6:15 m., from the causes and on the date stated above.

23a. SIGNATURE Wm G. Shaw, Jr M.D.	(Degree or title)	23b. ADDRESS Lee Hospital, Fayette, Mo	23c. DATE SIGNED 12-6-55
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	24b. DATE 12/2/55	24c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	24d. LOCATION (City, town, or county) (State) Glasgow, Missouri
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DATE REC'D BY LOCAL REG. 12-6-55	REGISTRAR'S SIGNATURE Mary K. Shello	25. FUNERAL DIRECTOR'S SIGNATURE Ralph A. Carr	ADDRESS Fayette, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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 *Ralph A. Carr*.....
Licensed Embalmer No. *33*

P. O. Address *Fayette*.....

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.