

pt. Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 - 1957

40429
STATE FILE NUMBER
Registrar's No. 5241

Registration District No. 149 Primary Registration District No. 1002

S. 300
ev. 1-57

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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, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1 | | Length of stay in lb 16 yrs | d. STREET ADDRESS (If outside, give location) 2621 Fuller | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Myron Kimberlin | | | 4. DATE OF DEATH Month Day Year 11 2 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-5-1900 | 9. AGE (In years last birthday) 57 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Man | | 10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN | 11. BIRTHPLACE (City and state or country) Iowa | | 12. CITIZEN OF WHAT COUNTRY? U. S. |
| 13a. FATHER'S NAME UNKNOWN | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 14. NAME OF HUSBAND OR WIFE none | |
| 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. 550-18-2885 | | 17. INFORMANT Jackson County Welfare Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Bronchogenic carcinoma IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH 162x |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Oct. 5, 1957 to Nov. 2, 1957 and last saw him alive on Nov. 2, 1957 Death occurred at 7:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <i>W. B. Weiler, M.D.</i> (Degree or title) | | | 22b. ADDRESS 24th & Cherry | | 22c. DATE SIGNED 11-5-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical | | 23b. DATE 11-9-57 | 23c. NAME OF CEMETERY OR CREMATORY Western Dental Coll. | | 23d. LOCATION (City, town, or county) K.P. Mo (State) |
| 24. FUNERAL DIRECTOR <i>W. B. Weiler</i> ADDRESS K.C. Mo. | | 25. DATE RECD. BY LOCAL REG. 11-8-57 | | REGISTRAR'S SIGNATURE <i>Neva Minshall</i> | |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



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 B. E. Weillert

Licensed Embalmer No. 4075
P. O. Address A. C. & M. O.

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.