

Health,
Welfare
Public
Service

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45120
STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 88

S. 300
1-56

1. PLACE OF DEATH COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miss.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston</u>		c. CITY OR TOWN <u>Charleston</u> <u>067</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>209 Vine St.</u>		d. STREET ADDRESS <u>209 Vine St.</u> (If outside, give location)	
Length of stay in 1b <u>1 yr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Kimble</u> Last <u>Kimble</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1883</u>
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Blackriver, Ia.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Lurins</u>	
14. MOTHER'S MAIDEN NAME <u>Irena McCrain</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>W. M. Kimble, Route 1, Charleston, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompenation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>auricular fibrillation</u>			<u>D.K</u>
DUE TO (c) <u>arteriosclerotic heart disease</u>			<u>D.K</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Was decompenated 7/12/1956</u>			19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a. m. _____ p. m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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 <u>7/13/56</u> to <u>5/10/57</u> and last saw ^{her} <u>him</u> alive on <u>12/19/57</u> Death occurred at <u>9:00 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. Charles Polwing M.D.</u> (Degree or title)		22b. ADDRESS <u>Charleston Mo</u>	22c. DATE SIGNED <u>12/18/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 15, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>
24. FUNERAL DIRECTOR <u>L.R. Sparks</u> ADDRESS <u>Charleston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-18-57</u>	26. REGISTRAR'S SIGNATURE <u>Dorothy B. Hathorn</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. Coroner cannot certify to a death due to natural causes.

RECEIVED
Miss. Co. Health Dept
County File No.
Date Filed 12-21-51

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.....
Edward A. Pappas

Licensed Embalmer No. 5022
P. O. Address 2501 Poplar
Cairo, Ill

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.