

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040032  
STATE FILE NUMBER  
5526

FILED DEC 11 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Osteopathic Hosp</b>		Length of stay in lb <b>16 years</b>	d. STREET ADDRESS <b>638 Garfield</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>DEAN</b> Last <b>KIMZEY</b>			4. DATE OF DEATH Month <b>11</b> Day <b>21</b> Year <b>1958</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1906</b>	9. AGE (In years last birthday) <b>52</b>	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>xxx</b>	11. BIRTHPLACE (City and state or country) <b>Harrison Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Dean</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Winland</b>	14. NAME OF HUSBAND OR WIFE <b>Willial Kimzey</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>500-22-5563</b>	17. INFORMANT <b>KIMZEY</b> Address <b>638 Garfield K.C.Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Papillary Serous cyst Adenocarcinoma of the ovaries,</b>	<b>3 years.</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)		19. WAS AUTOPSY PERFORMED? 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.) <b>1750</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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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
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21. I attended the deceased from **October 2, 1950** to **November 21, 1958** last saw her alive on **November 20, 1958**  
Death occurred at **8:20 a.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>C. Anderson, D.O.</b>	22b. ADDRESS <b>2425 Independence Boulevard Kansas City, Missouri</b>	22c. DATE SIGNED <b>11-21-58.</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-24-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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24. FUNERAL DIRECTOR <b>FLORAL HILLS MEMORIAL CHAPELS, INC</b>	ADDRESS <b>11-22-58</b>	25. DATE RECD. BY LOCAL REG. <b>11-22-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

C.S. Anderson

MEDICAL CERTIFICATION

*over 1000*



**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 *D. J. Springer*  
Licensed Embalmer No. *13438*  
P. O. Address *J. C. Mc*

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.