Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001984
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 179 Primary Registration District No. 5673 Registrar's No. 15

1. PLACE OF DEATH
a. COUNTY: LINCOLN
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): MONROE TOWNSHIP — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 3 mi. East of Winfield — Length of stay in Hospital: 5 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: LINCOLN
c. CITY OR TOWN: WINFIELD C570 — Inside Limits: [redacted] No ☒
d. STREET ADDRESS (If outside, give location): 3 MILE EAST OF WINFIELD — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: CLARA Middle: JOANNIS Last: KIMBERLY

4. DATE OF DEATH: Month: JAN. Day: 21 Year: 1959

5. SEX: Female 6. COLOR OR RACE: white 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: JULY 6, 1892 9. AGE (In years last birthday): 66 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (City and state or country): HAMBURG, ILLINOIS
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: JOSEPH TAYON
13b. MOTHER'S MAIDEN NAME: SARAH NELSON
14. NAME OF HUSBAND OR WIFE: ADLIA KIMBERLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: A.S. Kimberly Address: Winfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 4201
INTERVAL BETWEEN ONSET AND DEATH

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 ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Nov 5, 1957 to Jan 21, 1959 and last saw her alive on Jan. 19, 1959
Death occurred at 830 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert M. Hull, M.D. (Degree or title)
22b. ADDRESS: Elsberry Mo.
22c. DATE SIGNED: 1-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 1-24-59
23c. NAME OF CEMETERY ~~OR CREMATORY~~: WINFIELD
23d. LOCATION (City, town, or county) (State): WINFIELD, MO

24. FUNERAL DIRECTOR: O. C. Ricks ADDRESS: Elsberry, Mo
25. DATE RECD. BY LOCAL REG.: 2-2-59
26. REGISTRAR'S SIGNATURE: Charlotte Leek

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

VS FEB 16 1959

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. 4017

P. O. Address Eldorado, Me

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.