

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018879
STATE FILE NUMBER

FILED JUN 9 1959 Registration District No. 316 Primary Registration District No. Registrar's No. 218

1. PLACE OF DEATH a. COUNTY St. Francois County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Rural St. Francois		c. CITY OR TOWN Festus	
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mineral Area Osteopathic Hospital		d. STREET ADDRESS (If outside, give location) 801 Huber	

3. NAME OF DECEASED (Type or print) First Laban Middle B. Last Kimbrell			4. DATE OF DEATH Month May Day 25 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1885	9. AGE (In years last birthday) 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Maker		11. BIRTHPLACE (City and state or country) Standberry, Missouri	
13. FATHER'S NAME C. C. Kimbrell			14. MOTHER'S MAIDEN NAME Jincy Brown		
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.		17. INFORMANT Address Mrs. Mabel Kimbrell, 801 Huber, Festus, Mo.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and Debilitation		INTERVAL BETWEEN ONSET AND DEATH Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Uremia		
DUE TO (c) Prostatic hypertrophy with obstruction		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 6:40 A 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
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21. I attended the deceased from **5-16-59** to **5-25-59** and last saw her alive on **5-24-59**
Death occurred at **6:40 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul J. Coan DO	22b. ADDRESS Farrington, Mo	22c. DATE SIGNED 5/28/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 27, 1959	23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	23d. LOCATION (City, town, or county) (State) Festus, Missouri
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24. FUNERAL DIRECTOR ADDRESS Vinyard Fun'l Homes, Inc., Festus, Mo.	25. DATE RECD. BY LOCAL REG. June 3, 1959	26. REGISTRAR'S SIGNATURE Eather Rudloff
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(Licensed Embalmer's Statement on Reverse Side)

hh, elfare, lic, rvice
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

0861 91 800

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.....
Keith B. Vinson

Licensed Embalmer No. 49

P. O. Address *Festa*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.