

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED FEB 16 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 3018

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County HENRY

(b) City or town CLINTON Mo.

(c) Name of hospital or institution: CLINTON General  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 1/2 (Specify whether years, months or days)

In this community 68 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Henry

(c) City or town Rural Route 1, 2  
(If outside city or town limits, write "RURAL.")

(d) Street No. Shawnee Township  
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No)  
If yes, name country —

3. (a) PRINT FULL NAME Jacob H. Kimes

3. (b) If veteran, name war —

3. (c) Social Security No. —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 9 year 42 hour 12 minute 45 A.M.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased: 12-27-1853  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1/5/42 to 1/8/42 1942 that I last saw him alive on 1/8/42 1942 and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months X Days 12 If less than one day hr. min.

Immediate cause of death: Cerebral Hemorrhage. Duration 3 days.

Due to \_\_\_\_\_

9. Birthplace CLINTON Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Other conditions: Hypertension  
(Include pregnancy within 6 months of death)

11. Industry or business \_\_\_\_\_

12. Name Mr. Kimes

13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name MARINA CRISSMAN

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

Major findings: 430

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant Mrs Ruth BROWN  
(b) Address Barlestone Okla

17. (a) Burial (b) Date thereof 1-11-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director Fred Wilkerson  
(b) Address Clinton Mo

19. (a) Jan 9, 1942 Georgia Ritchey  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Dr. P. Hallingworth (M. D. or other) M.D.  
Address Clinton Mo. Date signed 1/9/42

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 2-42-67

Date Filed 2-11-42

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Fred Welkerson*

Licensed Embalmer No. 2478

P. O. Address Clinton Ma

**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 this body is not embalmed, fact should be so stated above.