

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0014647

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 121 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

MY FILED 004 64

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>3 wks</u>	c. CITY OR TOWN <u>Clinton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Osteopathic Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>517 So. Orchard St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>VERA</u> Middle <u>-</u> Last <u>KIMBALL</u>			4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1964</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>4/10/1891</u>
9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper &amp; Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Appleton City, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U SA</u>		13a. FATHER'S NAME <u>W. E. Shoe</u>	
13b. MOTHER'S MAIDEN NAME <u>Kate Coffman</u>		14. NAME OF HUSBAND OR WIFE <u>Forrest Kimball</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. <u>495 36 5655</u>	17. INFORMANT <u>517 So. Orchard St.</u> <u>Forrest Kimball, Clinton, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Liver Failure &amp; toxemia</u>			<u>3 wks.</u>
DUE TO (b) <u>Obstruction of common duct</u>			<u>10 wks</u>
DUE TO (c) <u>Lymphosarcoma of rt. colon</u>			<u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			
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>1959</u> to <u>death</u> and last saw her/him alive on <u>4-29-67</u> Death occurred at <u>1-0</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. K. Wetzel, M.D.</u> (Degree or title)		22b. ADDRESS <u>Clinton, Mo.</u>	22c. DATE SIGNED <u>4-29-67</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 1, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cemetery</u>	23d. LOCATION (City, town, or county) <u>Clinton, Mo.</u>
24. FUNERAL DIRECTOR <u>Vansant Funeral Home, Clinton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 30, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Biggs</u>

USE BLACK INK OR TYPEWRITER RIBBON

DEPT. OF HEALTH

MAY 5 1964

RECEIVED

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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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert L. York

Licensed Embalmer No. 5193

P. O. Address Joplin, Mo.

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.

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