

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1166

1. PLACE OF DEATH

County Jackson
Township Kan
City K.C. Mo.

Registration District No. 399
Primary Registration District No. 3902
(No. 2003 - East 35th)

File No. _____
Registered No. 154
St. _____ Ward _____

2. FULL NAME

James Edward Shimp
(a) Residence No. St. Louis Okla St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah R. Shimp

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-12-1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>82</u>	<u>3</u>	<u>29</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Virginia

10. NAME OF FATHER J. R. Shimp

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

14. INFORMANT Wm J Shimp
(Address) 2003 - E - 35th St

15. FILED Jan 17 30 1930 M. M. Cronin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-11-1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131
932 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTOR (SECONDARY) Chronic Intermittent nephritis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Autopsy & Impulse

(Signed) Stanley S. Smith, M. D.

112, 1930 (Address) Popplewood

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Elmwood DATE OF BURIAL Jan 13 1930

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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