

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

OCT 23 1940
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31765
Do not use this space.

1. PLACE OF DEATH *Clinton*

(a) County..... *Clinton* Registration District No. *206*

(b) Township..... *Lathrop* Primary Registration District No. *4124*

(c) or City..... *Lathrop* (d) Street No. Registered No. *17*

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

2. PRINT FULL NAME *John Thomas Kimsey*

(a) Residence, No. *Lathrop, Mo.* (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Ruth Kimsey*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug. 20, 1889*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 0 15

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *farmer*

9. Industry or business in which work was done, as saw mill, bank, etc. *farming*

10. Date deceased last worked at this occupation (month and year) *May 1940* 11. Total time (years) spent in this occupation *50*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clay County, Mo.*

FATHER

13. NAME *Tom Kimsey*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Mrs. Ruth Kimsey, Lathrop, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Lathrop* DATE *9-7*, 19*40*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Demoss CRUNK, Lathrop, Mo.*

20. FILED *9-6*, 19*40* *E. B. ... Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 5, 1940*

22. I HEREBY CERTIFY, That I attended deceased from *Apr 1 - 1940* to *Sept 5 - 1940*

I last saw him alive on *Sept 5, 1940* Death is said to have occurred on the date stated above, at *2:00* p. m.

The principal cause of death and related causes of importance were as follows:

Tumor of Brain Date of onset

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? *X*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify *Yes*
 (Signed) *J. J. Longfield* M. D.
 (Address) *Lathrop, Mo.*

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31765-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **206**

Primary Registration District No. **4124**

Registrar's No. **17**

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

1. PLACE OF DEATH:

(a) County **Clinton**
(b) City or town **Patrap**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **John Thomas Kinsey**

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **51** Months **-** Days **15** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

10. DATE OF DEATH: Month **Sept** day **2** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Tumor of**

Brain
It was malignant.

Due to _____

Other conditions. **578**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 **J. Longford** (M.D. or other)

Address **Patrap, Mo.** Date signed _____

PHYSICIAN CERTIFICATION
Duration
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

