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

Do not use this space.

19 24 1929 0 0

1. PLACE OF DEATH

County: Cass — Registration District No. 151 — File No. 9883

Township: Coldwater — Primary Registration District No. 5215 — Registered No. 6

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME Sarah Catherine Simmons

(a) Residence. No. ..... 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: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Milton Simmons

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov-20-1855

7. AGE: Years 73 — Months 4 — Days 11 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Household Duties
(b) General nature of industry, business, or establishment in which employed (or employer): H Keeping
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Near Lone Jack Mo

PARENTS

10. NAME OF FATHER: E. M. Dealy
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Rebecca A. Frost
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn

14. INFORMANT: Mary A Conn
(Address): Hall, Mont

15. FILED 4-1 1929 John S Bundy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar-31-1929

17. I HEREBY CERTIFY, That I attended deceased from Mch 20, 1929, to Mch 30, 1929, that I last saw her alive on Mch 30, 1929, and that death occurred, on the date stated above, at 1:50 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of Rectum

About (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) 45 (duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) I N Parrish, M. D

Mch 30, 1929 (Address) Freeman Mo.

*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: Freeman Cemetery — DATE OF BURIAL: Apr-1-1929

20. UNDERTAKER: J.B. Hays — ADDRESS: Drexel 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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