

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

Do not use this space.

504

19  
FEB 1931

**PLACE OF DEATH**

County Cass  
Township Coldwater  
City                      (No.                     )

Registration District No. 151  
Primary Registration District No. 5215

File No.                       
Registered No. 2 St.                      Ward                     

**2. FULL NAME**

Le Roy 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 Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-2-1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 0 10

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. None  
(b) General nature of industry, business, or establishment in which employed (or employer).  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Coldwater Twp  
(STATE OR COUNTRY) Cass Co - Mo!

10. NAME OF FATHER O. M. Simmons  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Nellie Tribby  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kans.  
(STATE OR COUNTRY)

14. INFORMANT Chas. M. Simmons  
(Address) Lisle Mo.

15. FILED Jan 12 1931 REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-12-1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1931, to Jan 12, 1931, that I last saw him alive on Jan 11, 1931, and that death occurred, on the date stated above, at 9:55 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia  
11B  
int. A

(duration) yrs. mos. ds. 3  
CONTRIBUTORY acute  
(SECONDARY) Coryza  
(duration) yrs. mos. ds. 5

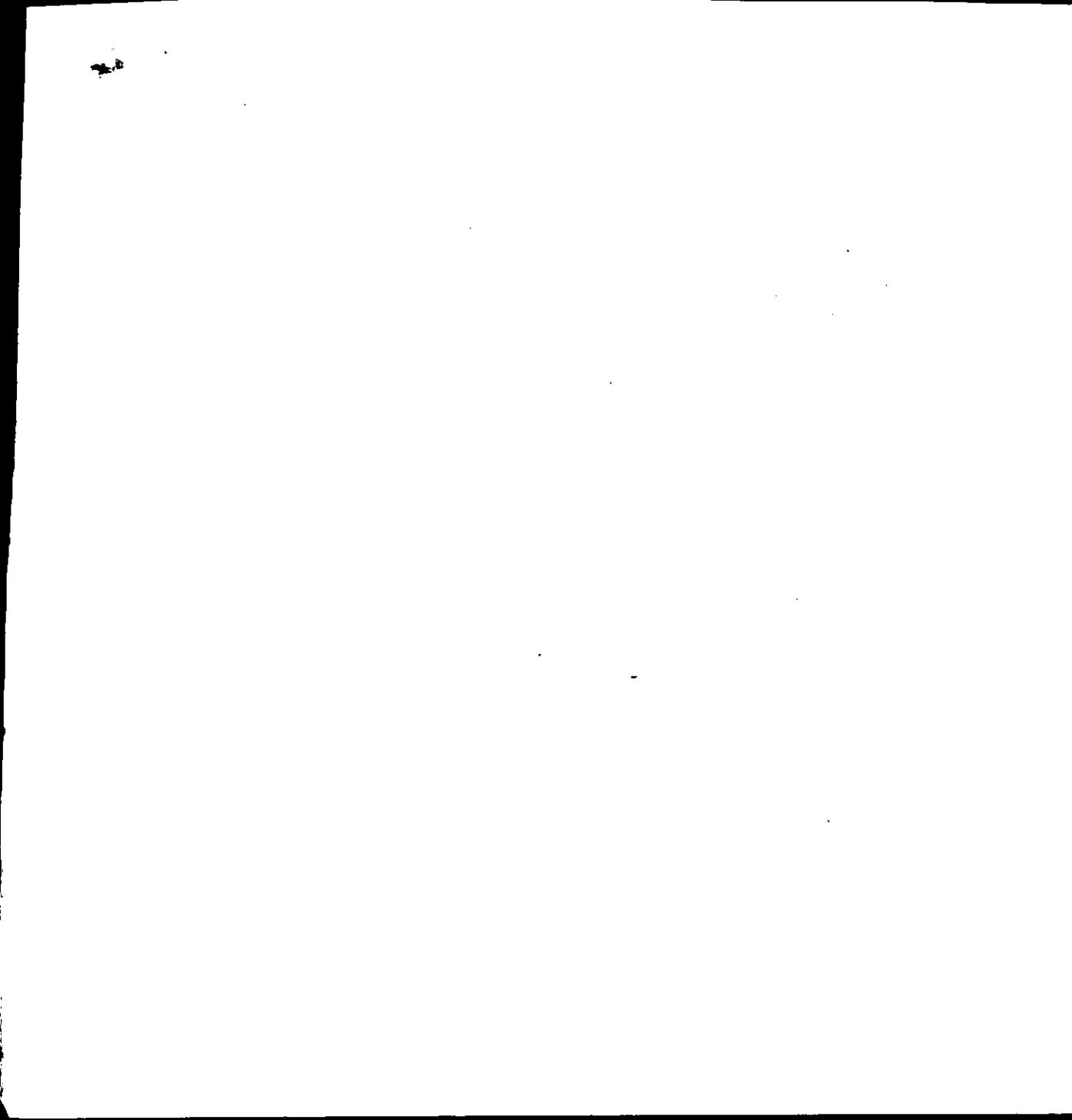
18. WHERE WAS DISEASE CONTRACTED? 11B  
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? no DATE OF                       
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) W. H. Parrish, M. D.  
Jan 14, 1931 (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 Jan 13 1931

20. UNDERTAKER                      ADDRESS Dreffel Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cass Registration District No. 13-1 File No. \_\_\_\_\_  
 Township Coldwater Primary Registration District No. 5215 Registered No. 2  
 City \_\_\_\_\_ (No) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME \_\_\_\_\_

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

MOTHER 15. MAIDEN NAME \_\_\_\_\_

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS)

20. FILED 2-12-31 John S. Burch Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 12 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.  
 (Address) \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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