

REC'D FEB 23 1939

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

3294
Do not use this space.

1. PLACE OF DEATH

(a) County NEWTON Registration District No. 615-
(b) Township MARION Primary Registration District No. 5817 Registered No. 3.
(c) City..... (d) Street No.....
(e) Length of residence in city or town where death occurred 45 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME AMANDA SIMPSON

(a) Residence, No. Granby Mo. Rt. 1. St. (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 FEMALE 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 J. H. SIMPSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC 27TH, 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 1 2

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. HOUSEWIFE
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) INDIANA

13. NAME ROBERTSON

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

15. MAIDEN NAME DONT KNOW

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

17. INFORMANT (ADDRESS) Jda Corner GRANBY RT L

18. BURIAL, CREMATION, OR REMOVAL PLACE POWERS CEM DATE 2/1/39 19.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) NEOSHO, MO

20. FILED Jan 31st 1939 Mrs. U.S. Chapman Legal Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 29th 1939.

22. I HEREBY CERTIFY That I attended deceased from Nov. 11, 1930, to Dec 21, 1938

I last saw her... alive on Dec 21, 1938 Death is said

to have occurred on the date stated above, at 9:30 P.m.

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

Kidney complications, with arterial hypertension, death ultimately due no doubt to thrombosis

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) Dr. E. D. Fletcher D.D.

(Address) Diamond, Mo.

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

9472
RECEIVED

District Health Officer No. 6,

District File Number

6-39-439

Date Filed

FEB 17 1939

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,

J. E. Byham

or by

Registered Apprentice No. _____, working under my personal supervision

Signed

J. E. Byham

Licensed Embalmer No.

2689

P. O. Address

Deosho 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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3294
Do not use this space.

1. PLACE OF DEATH

(a) County Newton Registration District No. 615-
(b) Township Marion Primary Registration District No. 2817 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Amanda Simpson

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-29 1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____ 1939 to _____ 1939

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

I last saw h. _____ alive on _____, 1939 Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 1 2

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

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

Supplementary
Kidney complications with arterial hypertension death ultimately due to Thrombosis
Other contributory causes of importance: Chronic Nephritis | 31
Date of onset _____

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

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

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____ Local Registrar.

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) W. D. Fletcher M. D. no
(Address) Diamond mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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