

REC'D MAR 9 1939

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

5658
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
 (b) Township Howell Primary Registration District No. 1100 Registered No. 857
 (c) City St. Louis Street No. 11 E. Sun Hosp 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

(a) Residence, No. 3242 Marshall 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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF late Simpson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March - 19 - 1860
 7. AGE YEARS 73 MONTHS 11 DAYS 6 If LESS than 1 day, hrs. or min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, 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

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

FATHER
 13. NAME Chas Simpson

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

MOTHER
 15. MAIDEN NAME Sarah Moore

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

17. INFORMANT (ADDRESS) Records Clerk
11 E. Sun Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Odesa Mo DATE Feb 26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rose & Stedman
11 E. Sun Hosp

20. FILED 7/26 1939 J. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-23-39
 22. I HEREBY CERTIFY, That I attended deceased from 2-19-39, 1939, to 2-23-39, 1939.
 I last saw h. alive on 2-23-39, 1939. Death is said to have occurred on the date stated above, at 9:00 a.m.

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

Diabetes Mellitus
Parkinson's Disease
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Other contributory causes of importance:
Cardiac decompensation

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no

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) P. A. DeMara, M. D.
 (Address) 11 E. Sun Hosp

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.

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,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.