

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 40255

Registration District No. 561

Primary Registration District No. 4330

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Bedon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
West North St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community Lifetime  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller  
(c) City or town Bedon  
(If outside city or town limits, write "RURAL")  
(d) Street No. West North St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME William Amos Simmons

8. (b) If veteran, name war No 9. (c) Social Security No. No

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Cora Alice 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 13 1863  
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Insurance Salesman

11. Industry or business \_\_\_\_\_

12. Name John H. Simmons

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

14. Maiden name Alsie Roark

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

16. (a) Informant's own signature J. H. Simmons

(b) Address Bedon, Mo.

17. (a) Bedon (b) Date thereof 12 21 39  
(Residence, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bedon

18. (a) Signature of funeral director Phillips Funeral Home

(b) Address Bedon, Mo.

19. (a) 12-2-1939 (b) Belle Haynes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 1  
year 1939 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1939 to 12-1-1939  
that I last saw him alive on 11-30, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 days  
nephritis  
Due to Arteriosclerosis 4 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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 E. B. Shelton M.D. (M. D. or other) 1

Address Bedon Mo Date signed 12-2-39

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE 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.

RECEIVED

Miller County Health Dep't.

County File Number 39-139

Date Filed 12-11-39

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

Louis D. Phellis, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Louis D. Phellis  
Licensed Embalmer No. 3663

P. O. Address Edison

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  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

40253  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Miller Registration District No. 561  
 (b) Township Eldon Primary Registration District No. 4330 Registered No. 75-  
 (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 Wm Arnes Simmons  
 (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

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wid)  
 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.  
76 5 18  
 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 \_\_\_\_\_  
 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. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_  
 20. FILED \_\_\_\_\_, 19\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 1, 1939  
 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:  
urthritis  
arterio sclerosis  
chronic nephritis  
 Other contributory causes of importance: \_\_\_\_\_  
 Date of onset \_\_\_\_\_  
 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) E. G. Shelton, M. D.  
 (Address) Eldon mo.

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PROVIDED BY LAW.

Local Registrar.

