

Registration District No. 415

Primary Registration District No. 42775-571

State File No. \_\_\_\_\_

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Jasper 2  
(b) City or town Reeds  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 yrs.  
years, months or days = 6 17

3. (a) PRINT FULL NAME JAMES OSCAR SIMPSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 14, 1861  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Real Estate Dealer

MOTHER FATHER

12. Name Robert Simpson

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

14. Maiden name Pauline

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

16. (a) Informant's own signature Fred Simpson

(b) Address Reeds, Mo.

17. (a) Burial (b) Date thereof Jan. 16, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reeds Cemetery

18. (a) Signature of funeral director W. M. ...

(b) Address Carthage, Mo.

19. (a) Jan. 19, 1940 (b) Martha ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from December 16, 1939, to Dec 25, 1939, that I last saw him alive on Dec 25, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Had injury 5 wks + previous

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) Manner of injury \_\_\_\_\_

23. Signature W. Russell Smith (M.D. or other)

Address Carthage, Mo. Date signed 1-15-40

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

District Health Officer No. 6,

District File Number 240-395

Date Filed FEB 12 1940

**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 J. W. K. [Signature]

Licensed Embalmer No. 814

P. O. Address Carthage, 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.**