

FILED MAR 12 1940

Registration District No. 318 Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2012 N. Summit 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2012 N. Summit
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME ADA BELLE SIMMONS

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

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

6. (b) Name of husband or wife Harry Simmons 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 28, 1886
(Month) (Day) (Year)

| 8. AGE | Years | Months | Days | If less than one day. |
|-----------|----------|-----------|------|-----------------------|
| <u>53</u> | <u>4</u> | <u>19</u> | | hr. min. |

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Jasper Garner
13. Birthplace Arkansas
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Wink
15. Birthplace Wink 19
(City, town, or county) (State or foreign country)

16. (a) Informant Friend Friend

(b) Address Walnut Grove, Mo.

17. (a) Burial (b) Date thereof Feb. 19 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director P. C. Williams

(b) Address Springfield, Mo.

19. (a) 2/19/40 (b) Chas. A. Meyer, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February, day 17th
year 1940 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him dead alive on 2-18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial insufficiency

Due to myocardosis

Due to _____

Other conditions Contusion of hip (l) 2 weeks previously
(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) accidental fall

(b) Date of occurrence about 2 weeks previously

(c) Where did injury occur? on Washington Ave. Underpass
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public sidewalk, Springfield, Mo.

While at work? pedestrian (Specify type of place) (e) Means of injury fall

23. Signature P. W. White (M. D. or other) M.D.

Address Coroner Greene County Date signed 2/19/40

Duration
Immediate cause of death
Due to
Due to
Other conditions
Major findings:
Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 R H Christie
Licensed Embalmer No. 3681
P. O. Address Springfield, 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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6644
Registrar's No. 169

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318

Primary Registration District No. 2001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Ada Belle Simmons

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 53 Months 4 Days 19 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____ 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name Unknown 15. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

16. (a) Informant 1 (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 4/18/40 (b) Chas. A. George (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 Feb day 17th year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
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? _____
(Specify type of place) _____
While at work _____ (e) Manner of injury _____
23. Signature R. Ned White M. D. or other) _____
Address Greene Co _____ Date signed _____

SUPPLEMENTARY

