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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8319

FILED MAR 14 1940

Registration District No. 827

Primary Registration District No. 4500

Registrar's No. 4

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

1. PLACE OF DEATH: Shelby
 (a) County Shelby
 (b) City or town Clarence Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (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 20 years. (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME John Henry Simpson
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: May - 3 - 1956
 (Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation contractor

11. Industry or business _____

MOTHER FATHER
 { 12. Name William Simpson
 { 13. Birthplace Missouri (City, town, or county) (State or foreign country)
 { 14. Maiden name Jules Stranahan
 { 15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Thos B Smith
 (b) Address Clarence Mo

17. (a) _____ (b) Date thereof 1-18-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Clarence Mo

18. (a) Signature of funeral director E. H. [unclear]
 (b) Address Clarence Mo

19. (a) 2-10-40 (b) ROY HAMILTON
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Shelby
 (c) City or town Clarence
 (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 16
 year 1940 hour 11 minute 30 p.m.
 21. I hereby certify that I attended the deceased from Mar 27, 1935 to Jan 16, 1940
 that I last saw him alive on Jan 15, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 10 yrs
 Due to _____
 Due to _____

Other conditions Cerebral apoplexy c 2 yrs
 (Include pregnancy within 3 months of death)
 Major findings: hemiplegia PHYSICIAN _____
 Of operations stone
 Of autopsy none
 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) no
 (b) Date of occurrence no
 (c) Where did injury occur? no (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? no (Specify type of place) (e) Means of injury no
 23. Signature D. J. Harlan (M. D. or other) _____
 Address Clarence Mo Date signed Feb 9 1940

RECEIVED

District Health Officer No. 10

District File Number 3-40-684

Date Filed

MAR 13 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 *E. E. Lippert*
Licensed Embalmer No. *878*
P. O. Address *Bellevue, W.*

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.