

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 334

Primary Registration District No. 3747

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Mercer *W. Va.*

(b) City or town Rural *11*

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 14 years
years, months or days

3. (a) PRINT FULL NAME William Ira Sims *524*

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 Married

6. (b) Name of husband or wife Daisy Sims

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Oct. 29 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>3</u>	<u>15</u>	hr. _____ min. _____

9. Birthplace Near Princeton Mo. *6*
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer *6*

11. Industry or business _____

12. Name Syrus Sims *6*

13. Birthplace Mo. *6*
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Applegate
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Nancy Sims

(b) Address Princeton Mo.

17. (a) Burial (b) Date thereof 2-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Home

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

(b) Address Princeton, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Near Princeton, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb. day 13th
year 1940 hour 2 minute AM M.

21. I hereby certify that I attended the deceased from Feb 13, 1940 to Feb 13, 1940
that I last saw him alive on Feb 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration _____

Due to Acetone Residues *6 days*

Due to Influenza *11 W 2 wks*

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Phys + Pathologist
Of operations Shifts occur, + P. & C.

Of autopsy none

PHYSICIAN Underline which 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? 493

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

23. Signature J. M. Petty (M. D. or other) _____
Address Princeton Mo Date signed 2/12-40

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

District Health Officer No. 11;

District File Number: 540-754

Date Filed: MAY 16 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.....

H. Swan Martin

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

Signed *H. Swan Martin*

District File Number.....

Licensed Embalmer No. *3760*

Date Filed.....

P. O. Address *Princeton, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-483

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 554

Primary Registration District No. 5747

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Washington
(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 _____
In this community _____ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME Wm Dea Simal

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

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

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

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

8. AGE: Years 54 Months 3 Days 15 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 13 (b) Mrs. Claud Thomas (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 13 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I 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? _____

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

23. Signature J. H. Perry (M. D. or other) _____
Address Princeton Mo Date signed _____

SUPPLEMENTAL

