

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43150
Registrar's No. 82

Registration District No. 538

Primary Registration District No. 2724

1. PLACE OF DEATH:

(a) County Madison
(b) City or town St. Francois
(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 79 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret 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 John H. Simmons 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 28 - 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 5 If less than one day hr. _____ min. _____

9. Birthplace Madison Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Crawford Pruett

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

14. Maiden name Mary Johnson

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

16. (a) Informant's own signature Marie Jackson

(b) Address Fredericktown Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 - 1940
(Month) (Day) (Year)

(c) Place: burial or cremation hattle Vans

18. (a) Signature of funeral director Stanley H Dixon

(b) Address Fredericktown Mo

19. (a) Dec 3 - 1940 (Date received local registrar) (b) S. A. S. Campbell Registrar's signature
By E. B. Stevenson

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison

(c) City or town Rural St. Francois
(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 Dec day 3 year 1940 hour 9 minute 45-9 M.

21. I hereby certify that I attended the deceased from _____, 19____, to Dec 3, 1940

that I last saw her alive on May 3 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral haemorrhage Duration _____

Due to Hypertension

Due to arterio-sclerosis

Other conditions (Include pregnancy within 3 months of death) g2N

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? 401

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

23. Signature S. Campbell (M. D. or other) _____

Address _____ Date signed _____

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.

19351

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.....

Licensed Embalmer No.....

P. O. Address.....

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.