S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 18 1942

Registration District No. 149

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 39956

Registrar's No. 4559

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3620 Paseo /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX (Specify whether
In this community 6 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 3620 Paseo
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Alice Cordelia Simpson

3. (b) If veteran, name war XX

3. (c) Social Security No. None

4. Sex Fe

5. Color or race Wh /

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Dr. J. T. Simpson

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

7. Birth date of deceased August (Month) 13 (Day) 1859 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 3 | 23 | hr. min. |

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Wm. Underwood
13. Birthplace (City, town, or county) Ky / (State or foreign country)

MOTHER
14. Maiden name Angeline Varbel
15. Birthplace (City, town, or county) Va. / (State or foreign country)

16. (a) Informant Mrs. Lee Parish

(b) Address 3620 Paseo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-8-42 (Month) (Day) (Year)

(c) Place: burial or cremation Holden, Mo.

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 12-8-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 6th year 1942 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec 1, 19 to Dec 6 19 42 that I last saw her alive on Dec 5 19 42 and that death occurred on the date and hour stated above.

Immediate cause of death Mr. Myocardelix — Duration Several yrs

Due to Arterio sclerosis

Due to 1869

Other conditions Fractured hip — 2 mths
(Include pregnancy within 3 months of death)

Major findings: Of operations Hip was nailed at Kc general Hosp.

Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Accident was not the direct cause of death

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence 2 mo. previous to death

(c) Where did injury occur? K 6123 Jack. Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fall in home Caused fracture (Specify type of place)

While at work? (e) Means of injury

23. Signature J. V. Bell (M. D. or other)

Address 437 Professional Bl. Date signed Dec 7-42

(Licensed Embalmer's Statement on Reverse Side)

Bill
Pay Bldg.

## 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 A. R. Hainschild

Licensed Embalmer No. 4159

P. O. Address Kansas city 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, fact should be so stated above.**