

FILED JUL 7 1948 255

Registration District No. 255

Primary Registration District No. 5377-4387

Registrar's No. 66

1. PLACE OF DEATH:

(a) County Oregon
 (b) City or town Alton Piney Twp.
 (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 Lifetime years, months or days)

3. (a) PRINT FULL NAME Mattie F. Simpson

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 Widowed
 6. (b) Name of husband or wife Peter C. Simpson 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased June 16 1867
 (Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 1 If less than one day hr. min.

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

10. Usual occupation Domestic

11. Industry or business

12. Name Samuel Ross

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

14. Maiden name Unknown
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant C. C. Simpson

(b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 5/19/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hall Cemetery

18. (a) Signature of funeral director Les Carr

(b) Address Thayer, Mo.

19. (a) 5/30/1948 (b) Thayer, Mo.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75
 (c) City or town Alton
 (If outside city or town limits, write "RURAL.") 0
 (d) Street No. (If rural, give location) 0
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 17 day 1948
 year 1948 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....;
 that I last saw h..... alive on....., 19.....;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation of Heart

Due to Arteriosclerosis Hypertension

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 Les Carr (M.D. or Registrar)
 Address Thayer, Mo. Date signed 5/30/48

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.....

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *July*
Registrar's No. *66*

Registration District No. *254* Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County *Oregon*

(b) City or town _____
(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 _____ years, months or days)

3. (a) PRINT FULL NAME *Mathe J. Simpson*

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 *w*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *June 16 1916*
(Month) (Day) (Year)

8. AGE: Years *25* Months *11* Days _____ If less than one day _____ min.

9. Birthplace *mo*
(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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* Day *17* Year *1943* Hour _____ Minute _____ M.

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

Immediate cause of death *acute dilation of heart*

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) _____

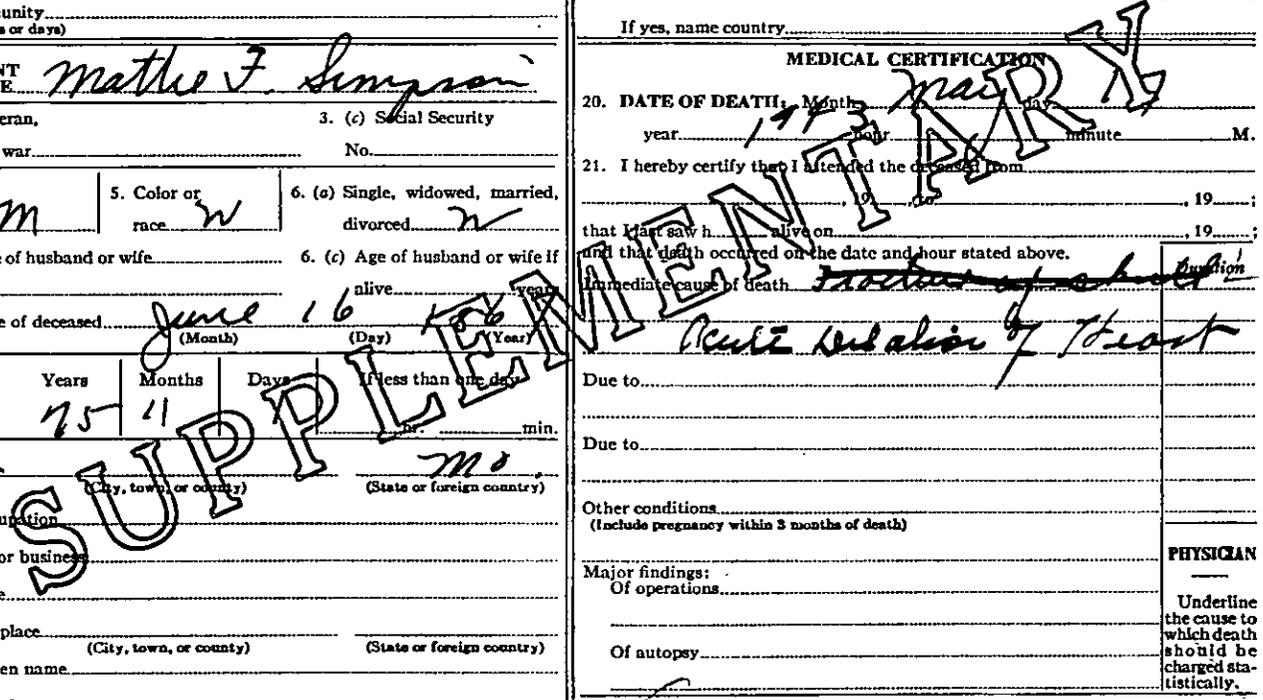
(b) Date of occurrence _____

(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 _____ (M. D. or other) _____
Address _____ Date signed _____



S-22083