

No. 2  
12-45  
17-39  
X47070

**FILED APR 7 1947**

Registration District No. 1.55

Primary Registration District No. 3.127

Registrar's No. 49

**I. PLACE OF DEATH:**

(a) County Jasper  
(b) City or town Wetzel City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
624 N. IOM  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 17 years years, months or days)

3. (a) PRINT FULL NAME Wm B 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 Married  
6. (b) Name of husband or wife Mar Simpson 6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased Nov 15 1868  
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 17 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Engineer

11. Industry or business Retired

MOTHER FATHER  
12. Name Hindings Simpson  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Fannie Garrison  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mar Simpson  
(b) Address Wetzel City Mo

17. (a) Burial (b) Date thereof April 4 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Springfield Memorial Park

18. (a) Signature of funeral director Wetzel City Und Co  
(b) Address Wetzel City Mo

19. (a) APR 4 1947 (b) G. H. Beckwith  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper  
(c) City or town Wetzel City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 624 N. IOM St  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 22nd  
year 1947 hour 2:30 minute P M.  
21. I hereby certify that I attended the deceased from 47 to April 2 1947  
that I last saw him alive on April 2 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 17 Mo

Due to Atherosclerosis + Hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 83A  
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) (c) Means of injury \_\_\_\_\_

23. Signature James Roberts (M. D. \_\_\_\_\_)  
Address Castroville Mo Date signed Apr 4 47

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

137

47-3-256

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**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.....

*B. A. Legan*

Licensed Embalmer No. 3979

P. O. Address. Webb 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.**