

S. No. 2
DM-5-43
v. 5-17-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28511

FILED SEP 5 1947

State File No.

Registration District No. 205

Primary Registration District No. 5877

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Altco (Rural) 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 62 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

(c) City or town Altco 0
(If outside city or town limits, write "RURAL") 3

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minnie Bell Simpson

3. (b) If veteran, name war --

3. (c) Social Security No. --

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16
year 1947 hour 10 minute 00 P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Samuel Simpson

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

7. Birth date of deceased Sept. 10 1876
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8/26, 1946, to 5/16, 1947;
that I last saw her alive on 5/15, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Senil Anasarca

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>8</u>	<u>16</u>	_____ hr. _____ min.

Due to Chr Myocarditis
& Chr Nephritis

Due to _____

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

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

10. Usual occupation Domestic

Major findings: _____

Of operations _____

Of autopsy _____

13/12

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

MOTHER FATHER

11. Industry or business _____

12. Name Robert T Teague 9

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

14. Maiden name Lucy Buntin 9

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

16. (a) Informant Mrs. N. B. Key

(b) Address Altco, Mo.

17. (a) Burial (b) Date thereof 5/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smith Cem.

18. (a) Signature of funeral director Deland Carter

(b) Address Phayer, Mo.

19. (a) Aug 9-47 (b) Mrs W C Key
(Date received local registrar) (Registrar's signature) 225

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) Means of injury _____

23. Signature W C Key (Reg. B. or other) _____
Address West Plains Mo. Date signed _____

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

RECEIVED

District Health Officer No. 5,

District ...

847483

Date Filed

8-30-47

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.