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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 24 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20126

State File No. ....

Registration District No. 199

Primary Registration District No. 5730

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Rural Drake Township  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. South West of Kirksville  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Elizabeth 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 widowed

6. (b) Name of husband or wife Joshua Simmons 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 14 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>7</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation housekeeping

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Michail Weber

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

14. Maiden name Leaa Spillman

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

16. (a) Informant Mrs. Frank Hays

(b) Address Novinger Mo

17. (a) Burial (b) Date thereof May 14 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pratt

18. (a) Signature of funeral director M. McCallum

(b) Address South Gifford Mo

19. (a) June 8 1948 Daphne Howerton  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12  
year 1948 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from May 11 1948 to May 12 1948  
that I last saw him alive on May 12 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis Duration 10 yrs.

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? 2

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

Signature [Signature] (M.D. or other) 90

Address Elmer Mo Date signed 5/12/48

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

RECEIVED

District Health Officer No. 10

District File Number 6-48-1089

Date Filed JUN 22 1948

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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 *W. N. McCallum*

Licensed Embalmer No. 2052

P. O. Address South Gifford 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.**