

S. No. 300  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26601**  
**3185**  
Registrar's No. \_\_\_\_\_

FILED AUG 26 1948

Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1712 Tracy  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 45 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Jackson  
(c) City or town K.C. (If outside city or town limits, write "RURAL")  
(d) Street No. 1712 Tracy AVE. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ORA WARD SIMMONS.  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 8 day 1  
year 1948 hour 7.10 minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 8/1/48, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race NE9A0 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife HENRY 6. (c) Age of husband or wife if alive 68 years  
7. Birth date of deceased: 4-18-1878  
(Month) (Day) (Year)

Immediate cause of death apoplexy  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions no  
(Include pregnancy within 3 months of death)

8. AGE: Years 70 Months 3 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Springfield MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation House Wife

Major findings: Of operations none  
Of autopsy none  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name E. D. Fields  
13. Birthplace Dent. Know 9  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Simmons  
(b) Address 1712 Tracy  
17. (a) Burial (b) Date thereof 8-5-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Highland C.E.M.  
18. (a) Signature of funeral director Brady Brown  
(b) Address 1708 Tracy  
19. (a) 8-4-48 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence no  
(c) Where did injury occur? no (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no  
While at work? no (Specify type of place) (e) Means of injury no  
23. Signature Henry B. Taylor M.D. or other \_\_\_\_\_  
Address 1605-8-18-48 Date signed 8-1-48

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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

*[Handwritten Signature]*  
.....

Licensed Embalmer No. *7388*

P. O. Address *K.C. 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.**