

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **25981**

FILED SEP 15 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3009</u>		Registrar's No. <u>871</u>			
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Ill</u> b. COUNTY <u>Peoria</u>					
b. CITY OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>4</u> <u>6yr. 10mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Peoria, Illinois</u>		d. STREET ADDRESS (If rural, give location) <u>611-Jayette St. Peoria</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home #1</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 5 1949</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>R. ARTHUR</u>		b. (Middle) <u>Roland</u>		c. (Last) <u>Simpson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 5 1949</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>Dec. 19, 1932</u>			
9. AGE (In years last birthday) <u>17</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 11 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Peoria, Illinois</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Charles Simpson</u>			13b. MOTHER'S MAIDEN NAME <u>Eva Hyatt</u>			14. NAME OF HUSBAND OR WIFE <u>---</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Disp. Records</u>		ADDRESS <u>Kirksville</u>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anoxia</u>				DUE TO (b) <u>Branchial pneumonia</u>				<u>1 min</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>pseudohypertrophic muscular dystrophy</u>								<u>2 days</u>	
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.								<u>15 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>7441</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>47</u> , to <u>Sept 5</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>49</u> , and that death occurred at <u>6:45 Am.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>M. T. Gutensahn D.D.</u>				23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>9-5-49</u>			
24a. BURIAL OR CREMATION REMOVAL (Specify) <u>---</u>		24b. DATE <u>9-5-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Glendale Memorial</u>		24d. LOCATION (City, town, or county) (State) <u>Peoria, Illinois</u>			
DATE REC'D BY LOCAL REG. <u>9-5-49</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert B. Davis Kirksville</u>					

RECEIVED SEP 10 1949
District Health Officer No. 10
District File Number 9-49-157
Date Recd SEP 10 1949

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 _____

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed Robert B. Davis
Licensed Embalmer No. 4219
P. O. Address Kirkville, 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.