

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

27521

130048

BIRTH NO. _____ REG. DIST. NO. 243 PRIMARY REG. DIST. NO. 3936 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY <u>NEWTON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>NEWTON</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>		13
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NEOSHO TWP.</u>			d. STREET ADDRESS (If rural, give location) <u>NEOSHO R#4</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>RACHEL</u> b. (Middle) <u>ANNA</u> c. (Last) <u>SIMONDS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 4. 1949</u>		
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 9. 1865</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>9</u>
IF UNDER 24 HRS. Days <u>25</u>	IF UNDER 4 HRS. Hours <u></u>	IF UNDER 15 MIN. Min. <u></u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>
11. BIRTHPLACE (State or foreign country) <u>DAVIS CITY IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>O. LOSEY</u>		13b. MOTHER'S MAIDEN NAME <u>MARY HORN</u>		14. NAME OF HUSBAND OR WIFE <u>G.A. SIMONDS</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 ADDRESS <u>MRS. WM. H. REED. HASTINGS. NEBR.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 da</u>		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		
			DUE TO (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4201</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)		
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>7-30</u> , <u>189</u> , to <u>8-4</u> , <u>1949</u> , that I last saw the deceased alive on <u>8-3-</u> , <u>1949</u> , and that death occurred at <u>7:45 P.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Warren M. Jones M.D.</u>			23b. ADDRESS <u>Neosho, Mo.</u>		23c. DATE SIGNED <u>8-13-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>8-6-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GIBSON</u>	24d. LOCATION (City, town, or county) (State) <u>NEOSHO MISSOURI</u>		
DATE REC'D BY LOCAL REG. <u>Aug. 13 1949</u>		REGISTRAR'S SIGNATURE <u>Debra C. Roman</u>	223	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Corley Thompson. Neosho Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. NEWTON Co. HEALTH UNIT
District File Number 849-138
Date Filed AUG 17 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 Booley Thompson

Licensed Embalmer No. 3259

P. O. Address Newsho Ma

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.