

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

18552

State File No. _____

MAY 14 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4372**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Arkansas b. COUNTY Stone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. View 8030	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) a. (First) Clarence b. (Middle) V. c. (Last) Simpson			4. DATE OF DEATH (Month) (Day) (Year) May 9, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov 11 1892	9. AGE (In years last birthday) 59 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Fireman		10b. KIND OF BUSINESS OR INDUSTRY Trail-road		11. BIRTHPLACE (City and State or Foreign Country) Iowa /	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Ernest Simpson		13b. MOTHER'S MAIDEN NAME Rowena McGranahan		14. NAME OF HUSBAND OR WIFE Abbie Simpson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Delores Davis, 1345 Ferguson Ave.	

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 mo. years	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor pulmonale			
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary fibrosis DUE TO (c) arteriosclerosis, generalized			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 525 X	

22. I hereby certify that I attended the deceased from **4/15, 1952**, to **5/9, 1952**, that I last saw the deceased alive on **5/9, 1952** and that death occurred at **8:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. S. Franklin (Degree or title) M.D.		23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 5/10/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-10-52		24c. NAME OF CEMETERY OR CREMATORY Hannibal, Missouri	

DATE REC'D BY LOCAL REG. MAY 10 1952		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe - 4700 Washington	
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m98 (Licensed Embalmer's Statement on Reverse Side)

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

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 *J. Wm B. Embler* _____

Licensed Embalmer No. *3653* _____

P. O. Address *St Louis 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.