

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

29606

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

File No.

Township.....

Primary Registration District No. 1001

Registered No. 1063

City St. Joseph, Mo.

(No. 2605 South 6th Street, St. Ward)

2. FULL NAME Samuel Simpson

(a) Residence. No. 2605 South 6th St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
74 Unknown Unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown

14. INFORMANT Fleeman Funeral Home
(Address) 1208 Francis

15. FILED 10/18/27 John H. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 16, 1927

17. I HEREBY CERTIFY That I attended deceased from Oct. 16, 1927 to Oct. 16, 1927, that I last saw him alive on Oct. 16, 1927, and that death occurred, on the date stated above, at Unknown.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mysocarditis Chronica
93C

CONTRIBUTORY (SECONDARY) 90B

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH:.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? Presence of Bacteria
(Signed) Dr. Elmer C. [Signature] M. D.

10/18/27 (Address) St. Joseph, Mo.

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL for anatomical purposes
Hicksville, Mo. DATE OF BURIAL Oct. 18, 1927

20. UNDERTAKER Fleeman Funeral Home ADDRESS 1208 Francis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

