

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

1 PLACE OF DEATH

County Worth  
Township Fitchell  
or  
Village  
or  
City Grant City (NO

Registration District No.

903

File No.

Primary Registration District No.

4545

Registered No.

21

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Samuel Simmons

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH Feb 28 1856 (Month) (Day) (Year)

7 AGE 71 yrs. 9 mos. 10 ds. If LESS than 1 day...hrs. or...min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Merchant (b) General nature of industry business, or establishment in which employed (or employer) same

9 BIRTHPLACE (City or town, State or foreign country) Ohio

10 NAME OF FATHER Joseph Simmons 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) N.Y. 12 MAIDEN NAME OF MOTHER Ann Reese 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) N.Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Dr. Vern Simmons (Address) Grant City Mo

15 Filed Dec 10 27 1927 John Andrews Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 8 1927 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 23 1927 to Dec 8 1927 that I last saw him alive on Dec 8 1927 and that death occurred, on the date stated above, at 6:45 p.m.

THE CAUSE OF DEATH\* was as follows:  
Pulmonary Edema  
SV  
1118  
463 one (Duration) yrs. mos. ds.

CONTRIBUTORY Malignant tumor (Secondary) abdominal (Duration) yrs. mos. ds. (Signed) Dr. W. Mills M. D. 12-13- 1927 (Address) Grant City Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Grant City Cem DATE OF BURIAL Dec 12 1927

20 UNDERTAKER Andrews Bros ADDRESS Grant City

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Worth

Registration District No. 903

File No. ....

Township Grant City

Primary Registration District No. 4345

Registered No. 21

City Grant City

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... 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**

M

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

M

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

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

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**14.**

INFORMANT (Address)

FILED

2/10/28

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Dec 8 1927

**17.**

I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on ..... 19....., and that death occurred, on the date stated above at ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pulmonary Edema  
Possibly the result of  
Asphyxia (duration) yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, .....

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

WAS THERE AN AUTOPSY? No autopsy

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... M. D.

, 19 (Address)

\*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**

**DATE OF BURIAL**

19

**20. UNDERTAKER**

**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE short CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

S-37283