

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

Do not use this space.

13807

PLACE OF DEATH

County Bates
Township
City Butler

Registration District No. 50
Primary Registration District No. 3064

File No.
Registered No. 22
St. _____ Ward)

2. FULL NAME

Ruben Green Simmons

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Mrs Florence Simmons

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 13 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 | 6 | 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Kentucky

10. NAME OF FATHER Ruben P. Simmons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Wester Ann Davis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Lizzie A Morris (Address) Overseats Mass

15. Filed 4/30, 1929 Anna L Culver REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1929, to Apr 29 1929 that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 7:40 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:**

Apoplexy
9 1/2 (duration) yrs. mos. da.

CONTRIBUTORY Arterio Sclerosis (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH? 7/40

DID AN OPERATION PRECEDE DEATH? DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) R. G. Kahler, M. D. 4/30, 1929 (Address) Butler 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 Oak Hill DATE OF BURIAL May 1 1929

20. UNDERTAKER Culver ADDRESS Butler Mo

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.

MAY 23 1929
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RECORD

