

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

Do not use this space.

15507

1 20 1929
PLACE OF DEATH
County Dejeu
Township King
City St. Louis (No. 1)

Registration District No. 636
Primary Registration District No. 5840

File No. _____
Registered No. 29
St. _____ Ward _____

2. FULL NAME William T. Simpson
(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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1874 April 24

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 2 26

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

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

PARENTS

10. NAME OF FATHER Richard Simpson

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

12. MAIDEN NAME OF MOTHER Fronia Jones

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

14. INFORMANT R. T. Simpson
(Address) 1815. 2 no 1

15. FILED 4/20, 1929 Enoch Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 20 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1929, to April 20, 1929, that I last saw him alive on April 15, 1929, and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs

23 (duration) 8 yrs. mos. da.
CONTRIBUTORY (SECONDARY) 31 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, Williamson Mo 1928

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. T. Puffer M. D.
, 19 (Address) Five No.

*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 Williamson DATE OF BURIAL 4/21 1929

20. UNDERTAKER Neighon ADDRESS _____

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**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 Oregon

Registration District No. 636

File No.

Township Cash

Primary Registration District No. 5-840

Registered No. 29

City (No.) St. Ward

2. FULL NAME

William T. Simpson

(a) Residence. No. St. Ward. (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 M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 24 - 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
54 71 26

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)

15. FILED 7/10, 19 Enoch Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 20 1899

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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?

(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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

1929

15507