

MAY 20 1929

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

Do not use this space.

15754

1. PLACE OF DEATH

County St. Clair
Township Acadola
City Acadola (No. _____ St. _____ Ward)

Registration District No. 765
Primary Registration District No. 4460

File No. _____
Registered No. 14

2. FULL NAME

Jewell Elaine 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. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 28-1925

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
4 3 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child
(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) Missouri

10. NAME OF FATHER Sam Simmons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Margaret My Braden

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Sam Simmons
(Address) Acadola Mo.

15. FILED 37 1929 Kuth Secors
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1929

17. I HEREBY CERTIFY, That I attended deceased from April 5 1929, to April 8 1929, and that I last saw him alive on April 8 1929, and that death occurred, on the date stated above, at 1:30 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Measles with Complications of Pneumonia - Parotitis

107A (duration) yrs. mos. 10 ds.
CONTRIBUTORY Measles (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) E. B. Chaffin M. D.

, 19 29 (Address) Acadola 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 Pleasant Mount Cem DATE OF BURIAL 4/9 1929

20. UNDERTAKER Chaffin ADDRESS Acadola

WHITE - COMPLETE, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

