

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

Do not use this space.

33605
96

1. PLACE OF DEATH

County Howell Registration District No. 384
Township _____ Primary Registration District No. 477
City West Plains (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Jane 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 fe 4. COLOR OR RACE wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Simpson

7. DATE OF BIRTH (MONTH, DAY AND YEAR) 11
AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 11 26

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

9. BIRTHPLACE (CITY OR TOWN) Camden Mo
(STATE OR COUNTRY) Mo

10. NAME OF FATHER G. W. Pitner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wash. Co.
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Ella Dawn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wash. Co
(STATE OR COUNTRY) Mo

INFORMANT Sal Hecatt
(Address) _____

FILED 10-24-29 O.P.A. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-14-1929

17. I HEREBY CERTIFY, That I attended deceased from 7:30 - 1929, to 10-14- 1929, that I last saw him live on 10-10- 1929, and that death occurred, on the date stated above, at 11 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis - Chronic

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

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

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no

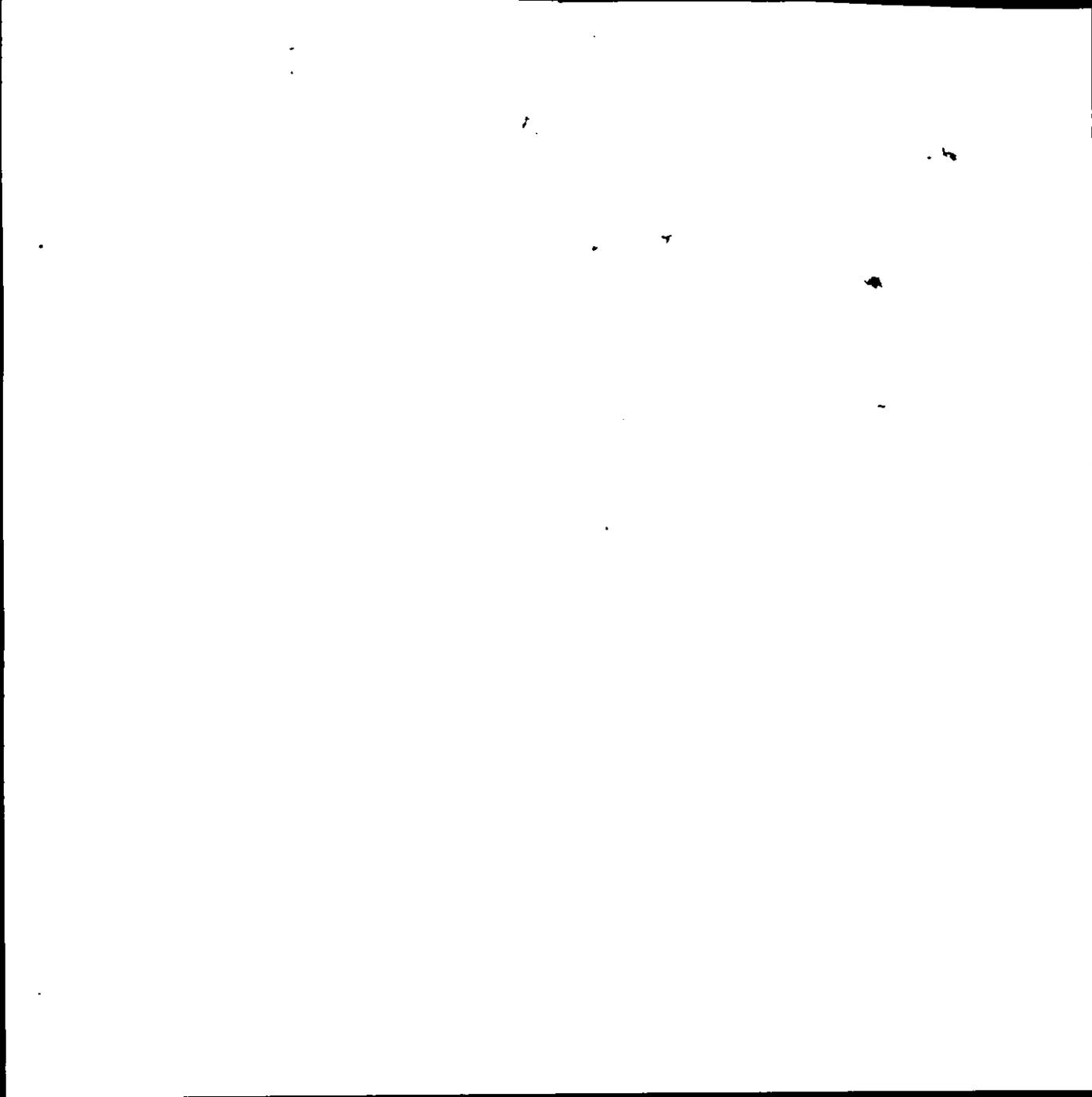
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. Claude Bohner, M. D.

10-18-1929 (Address) West Plains, 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 Evergreen Cent DATE OF BURIAL Nov 17 1929

20. UNDERTAKER W. C. Farland ADDRESS West Plains



**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 Howell Registration District No. 384 File No. 96
 Township _____ Primary Registration District No. 4227 Registered No. _____
 City West Plains (No. _____) St. _____ Ward _____

2. FULL NAME

Jane 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. 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) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 18 - 1875

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|-----------|-----------|-----------|------|----------------------------------|
| <u>53</u> | <u>11</u> | <u>26</u> | | |

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 11-24-1929 OSA Heinrich
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 - 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____ slip 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.

_____ (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

S-33605