

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

Do not use this space.

37436

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 723 West 38th St. St. _____ Ward)

File No. _____
 Registered No. 4906

2. FULL NAME Thomas Edward Simpson
 (a) Residence. No. 723 West 38th St. St. 6 Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE Colored	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 1, 1886		
7. AGE 43	YEARS 1	MONTHS 6
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Janitor (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Monsuratt
 (STATE OR COUNTRY) British West Indies

PARENTS	10. NAME OF FATHER James Simpson
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) British W, Indies
	12. MAIDEN NAME OF MOTHER Mary Ann Simpson
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) British W. Indies

14. INFORMANT Ella Gordon
 (Address) Cincinnati, Ohio

15. FILED 11/29/29 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/27 1929
 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:
Arteriosclerosis
9/10/29
 CONTRIBUTORY (SECONDARY) Arteriosclerosis
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Stanley M. Hales M. D.
11/7 29 (Address) Holy Crown
 *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 Highland DATE OF BURIAL Nov. 29, 19 29

20. UNDERTAKER Adkins Bros. ADDRESS 2000 E. 12th

WRITE PLAINLY, 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.

2936

