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

Do not use this space.

8866

1. PLACE OF DEATH
County Jackson — Registration District No. 390 — File No. 1245
Township Kaw — Primary Registration District No. 1092 — Registered No. 1245
City KC MO (No. General Hospital #2 St. ..... Ward)

2. FULL NAME Doc Simpson
(a) Residence. No. 1125 W. 25th St., 4 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Col.	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
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8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor.
(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) Ark.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT Record Clerk
(Address) General Hospital #2

15. FILED 3/20, 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-15 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-11, 1930 to 2-15, 1930 that I last saw him alive on 3-15, 1930 and that death occurred, on the date stated above, at 3:35 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
92A
93C (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Unknown
DID AN OPERATION PRECEDE DEATH? NO DATE OF
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [signature], M. D.
3/16, 1930 (Address) General Hosp #2

*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
Batesville Ark.	3-23 1930

20. UNDERTAKER	ADDRESS
West, Appleton & Jones	1600 E. 19th

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.

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