

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

Do not use this space.

37092

**1. PLACE OF DEATH**

County Randolph - Registration District No. 735  
 Township \_\_\_\_\_ Primary Registration District No. 3034  
 City Moberly (No. Wabash Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 445  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward Hallsville Mo  
 (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Maggie Simons</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec. 26<sup>th</sup> 1856</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>73</u>	<u>10</u>	<u>29</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Section Foreman  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer Wabash. R.R.

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Guerdon Simons  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 12. MAIDEN NAME OF MOTHER Unknown  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) "

**14.**

INFORMANT Mrs. Maggie Simons  
 (Address) \_\_\_\_\_

**15.**

FILED 11/25, 1930 Dr. Thos. S. Fleming  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov. 25, 1930.  
 that I last saw him alive on Nov. 25, 1930, and that death occurred, on the date stated above, at 1:05 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic myocarditis

**CONTRIBUTORY (SECONDARY)**

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH Hallsville, Mo.

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory  
 (Signed) Wm. E. Kaiser, M. D.

11-25<sup>th</sup>, 1930 (Address) Wabash Hospital

\*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**

Hallsville, Mo      11-28<sup>th</sup> 1930

**20. UNDERTAKER**      **ADDRESS**

Kilaborn and Son      Moberly

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.

DEC 22 1930

