

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

Do not use this space.

Cecil Board
39123

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 297
City Springfield (No. 1952 n. Grant)

File No. _____
Registered No. 966
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1952 n. Grant 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucy A. Simpson
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 31 - 1866
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 11 26

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

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

PARENTS
10. NAME OF FATHER Samuel Simpson
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) Unknown

14. INFORMANT B. P. Simpson
(Address) Springfield Mo.

15. FILED 2-19-30 For Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1930
17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1930, to only 1930, and that I last saw him alive on Dec 12, 1930, and that death occurred, on the date stated above, at 6:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

41.33 Carcinoma of Stomach
(duration) yrs. 6 mos. ds. _____
CONTRIBUTORY (SECONDARY) 44A
(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? no

WHAT TEST CONFIRMED DIAGNOSIS Laboratory + Clinical
(Signed) [Signature] M. D.
Dec 27, 19 30 (Address) - 413 Holladay Bldg

*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 Sixon Mo DATE OF BURIAL Dec 28 1930

20. UNDERTAKER W. Klingner + Co ADDRESS Springfield, Mo.

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.

44610 1930

958