

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

Do not use this space.

39127

1. PLACE OF DEATH  
 County Greene Registration District No. 318  
 Township Springfield Primary Registration District No. 2201  
 City Springfield (No. Springfield Clinic) St.                      Ward                       
 Registered No. 971

2. FULL NAME Althoush Simons  
 (a) Residence. No. Springfield Clinic 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF not known  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. about 74  
 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) Laborer  
 (c) Name of employer                       
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 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) Unknown

14. INFORMANT Julia Payne  
 (Address) 1823 N. Clay  
 15. FILED 12-29-30 Lon Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-27-1930  
 17. I HEREBY CERTIFY, That I attended deceased from 12-9-1930 to 12-27-1930  
 that I last saw him alive on 12-27-1930, and that death occurred, on the date stated above, at 7:35 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Dementia  
 (duration) yrs. mos. da.                       
 CONTRIBUTORY Dementia  
 (SECONDARY) (duration) yrs. mos. da.                       
 18. WHERE WAS DISEASE CONTRACTED at home  
 IF NOT AT PLACE OF DEATH                       
 DID AN OPERATION PRECEDE DEATH?                      DATE OF                       
 WAS THERE AN AUTOPSY?                       
 WHAT TEST CONFIRMED DIAGNOSIS?                       
 (Signed) H. H. Armstrong M. D.

12-29-1930 (Address) 617 30th Ave. S. E. Okla. City, Okla.  
 \*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 Nashwood Cmn DATE OF BURIAL Dec 29 1930  
 20. UNDERTAKER W. Campbell ADDRESS 869 Wash

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD (Armstrong)  
 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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