

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

Do not use this space.

JUL 24 1935

1. PLACE OF DEATH

County Macon
Township Macon
City Macon

Registration District No. 533
Primary Registration District No. 3027

File No. 20343
Registered No. 179
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ 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.

Philip Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE Edith Simmons
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 9 1880
7. AGE YEARS MONTHS DYS If LESS than 1 day, _____hra. or _____min.
57 11 16

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Office accountant
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Mo Missouri
13. NAME Geo. C. Simmons
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Middleboro Mass

MOTHER

15. MAIDEN NAME Emily Pipkin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Middleboro Missouri

17. INFORMANT (ADDRESS) Mrs Ralt Barrow Macon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oakwood DATE June 27 1935

19. UNDERTAKER (ADDRESS) Albert Skiffner Macon Mo

20. FILED 7/11 1935 Leola Newton Registrar.

MEDICAL CERTIFICATE OF DEATH

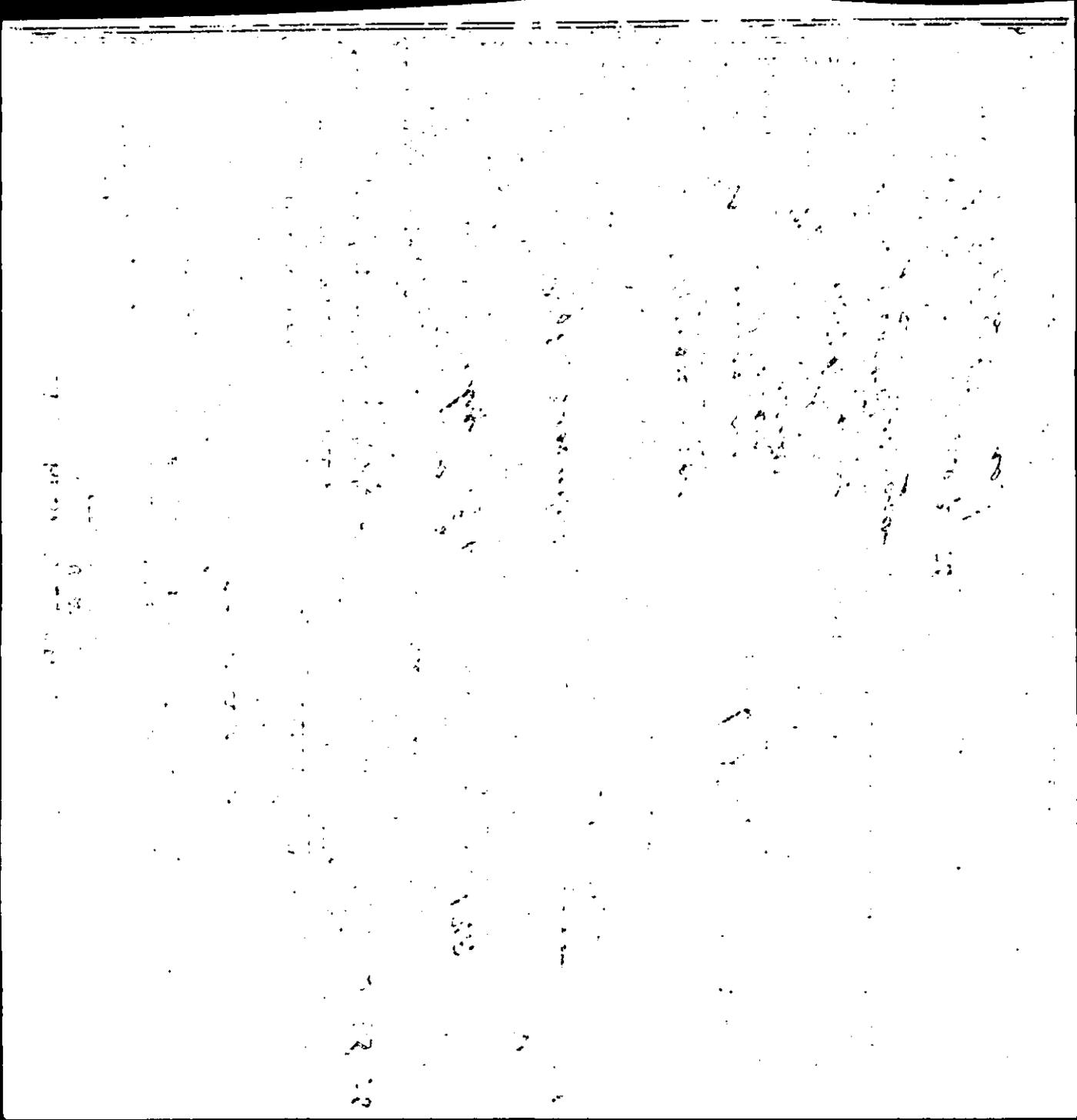
21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25, 1935
22. I HEREBY CERTIFY, That I attended deceased from April 19 1935 to June 25 1935
I last saw him alive on June 25 1935. Death is said to have occurred on the date stated above, at 10:17 p. m.

The principal cause of death and related causes of importance were as follows:
Adeno-carcinoma Date of onset Apr 1934
~~Prostate gland~~
lung and glands of neck

Other contributory causes of importance:
None
Name of operation Reduction of prostate Date of 1934
What test confirmed diagnosis? Curee Was there an autopsy? No
Laboratory

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) J. J. Roseway, M. D.
(Address) Macon Mo



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

INFORMED BY THE DECEASED OR HIS NEAREST RELATIVE
 FOR THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Macon Registration District No. 5-33 File No. _____
 Township _____ Primary Registration District No. 3027 Registered No. 179
 City Macon (No. _____) St. _____ Ward _____

2. FULL NAME

Philip Simmons

(a) Residence, No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or A.M./P.M.
34 11 16

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED 7/10 1935 Leota Newton Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25, 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I first saw the deceased alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Carcinoma tongue and glands of neck
Primaries in tongue

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____

(Signed) J. P. Kronoway, M. D.
 (Address) Macon Mo.

20343

AUG 6 1953