

REC'D FEB 15 1939

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

2355  
Do not use this space.

93

## PLACE OF DEATH

a) County GREENE Registration District No. 876  
 b) Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. \_\_\_\_\_  
 c) City SPRINGFIELD (d) Street No. Springfield Baptist Hospital St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

a) Residence, No. 512 Anna Mary Simpson St. Russellville, Mo.  Russellville, Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Female 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 W. E. Simpson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 18-1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
56 7 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home wife  
 9. Industry or business in which work was done, as 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) Newton Stewart Ind.

13. NAME Fredrick Feller

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

15. MAIDEN NAME Berna Maertzke

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

17. INFORMANT (ADDRESS) E. P. Simpson Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Local Cemetery DATE Feb. 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. W. Thomas Springfield, Mo.

20. FILED Jan 30 1939 Local Registrar 270 Address Springfield Mo

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/30/1939

22. I HEREBY CERTIFY, That I attended deceased from 1/18/1939, to 1/30/1939

I last saw her alive on 1/30/1939. Death is said to have occurred on the date stated above, at 1:30 p.m.  
 The principal cause of death and related causes of importance were as follows:

Myocarditis chr. (with auricular fibrillation)

Date of onset - Summer 1938

Other contributory causes of importance: Acute nephritis

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) Ray D. Callaway M. D.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

*Ralph Thiem*

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

*Ralph Thiem*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

2355-  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Greene Registration District No. 318  
 (b) Township Springfield Primary Registration District No. 2001 Registered No. 93  
 (c) City Springfield (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Anna Mary Simpson  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
 (write the word)

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 min.  
56 7 12

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as 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) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19.

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED Mar 11 1939 Chas A George Md Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/30 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw h \_\_\_\_\_ 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:  
Myxo Carditis  
with auricular fibrillation  
131  
 Date of onset chr

Other contributory causes of importance:  
Acute Nephritis  
Chronic

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) Geo D. Callaway, M. D.  
 (Address) Springfield Mo

SUPPLEMENTAL

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

S-2355