

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.

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

10900

Do not use this space.

1. PLACE OF DEATH *Henry*
(a) County *Henry* Registration District No. *328*
(b) Township *Leighton* Primary Registration District No. *3017*
(c) City *Leighton* (d) Street No. _____ Registered No. _____
(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 *Robt. Lee Sims*
(a) Residence, No. _____ St. ☐ (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 <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>infant</i>			21. DATE OF DEATH (MONTH, DAY, AND YEAR) <i>2-15-39</i> , 19	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					22. I HEREBY CERTIFY, That I attended deceased from <i>Feb. 11</i> , 19 <i>39</i> , to <i>Feb. 15</i> , 19 <i>39</i>	
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>12-31-38</i>					I last saw him alive on <i>Feb. 14</i> , 19 <i>39</i> . Death is said to have occurred on the date stated above, at <i>12</i> <i>PM</i> .	
7. AGE	YEARS <i>1</i>	MONTHS <i>1</i>	DAYS <i>15</i>	If LESS than 1 day, _____ hrs. or _____ min.	The principal cause of death and related causes of importance were as follows: <i>Broncho-pneumonia of a few days duration</i>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.				Date of onset	
	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) <i>Leighton</i> (STATE OR COUNTRY) <i>Mo</i>						
FATHER	13. NAME <i>Robt Sims</i>					
	14. BIRTHPLACE (CITY OR TOWN) <i>Mo</i> (STATE OR COUNTRY) <i>Mo</i>					
MOTHER	15. MAIDEN NAME <i>Hazel Knapp</i>					
	16. BIRTHPLACE (CITY OR TOWN) <i>Mo</i> (STATE OR COUNTRY) <i>Mo</i>					
17. INFORMANT <i>Robt Sims</i> (ADDRESS)						
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Placent Hill</i> DATE <i>2-15-39</i>						
19. FUNERAL DIRECTOR (NAME) <i>Gypsonis</i> (ADDRESS)						
20. FILED <i>2-15-39</i> <i>Leighton</i> Local Registrar.						
					Name of operation _____ Date of _____	
					What test confirmed diagnosis? <i>Clinical only</i> Was there an autopsy? <i>no</i>	
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) <i>B. H. Cullers</i> , M. D. (Address) <i>Leighton, Mo.</i>						

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STATE OF OHIO
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

RECEIVED

District Health Officer No. 111

District File Number 39-171

Date Filed MAR 24 1939

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,

or by

Registered Apprentice No. ; working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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

10900
Do not use this space.

1. PLACE OF DEATH

(a) County Brandy

Registration District No. 328

(b) Township Trenton

Primary Registration District No. 3017

(c) City Trenton

(d) Street No. _____

(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 Robt Lee Sims

(a) Residence, No. _____

St. ☐

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

infant

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.

1

15

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)

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. FUNERAL DIRECTOR
(ADDRESS)

20. FILED

19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-15-1899

22. I HEREBY CERTIFY, That I attended deceased from

19____ to 19____

I last saw him 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:

Branchio Pneumonia

few day duration

1070

Other contributory causes of importance:

no measles, whooping cough

etc.

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. H. Cullers, M. D.

(Address) Trenton

MAY - 3 1959