

MAY 22 1939

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

15987

Do not use this space.

1. PLACE OF DEATH  
(a) County St. Francois Registration District No. 773  
(b) Township Franklin Primary Registration District No. 4469  
(c) City Farmington (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 Leora Simpson  
(a) Residence, No. 207 N 3rd St Farmington Mo. (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
- 5A. IF MARRIED, WIDOWED, OR DIVORCED  
(HUSBAND OR WIFE OF) Robert Simpson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 7<sup>th</sup> 1892
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
46 " 11 26
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House 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) Farmington Mo
- FATHER  
13. NAME Leora Murphy  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Farmington Mo
- MOTHER  
15. MAIDEN NAME Ada Baker  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Farmington Mo
17. INFORMANT (ADDRESS) Robert Simpson Farmington Mo.
18. BURIAL, CREMATION, OR REMOVAL  
PLACE Colored Memorial DATE 4-4 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wendell Wood Co Farmington Mo.
20. FILED April 4, 1939 B. J. Robinson Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 2 1939
22. I HEREBY CERTIFY, That I attended deceased from April 1 1939, to April 2 1939  
I last saw her alive on April 2 1929. Death is said to have occurred on the date stated above, at 8 m.  
The principal cause of death and related causes of importance were as follows:  
apoplexy  
arterio sclerosis
- Other contributory causes of importance:  
arterio sclerosis
- 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) Dr. Clyde C. Winters M. D.  
Farmington Mo (Address)

Date of onset  
4-1-39

AUG 31 1954

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, .....

*John A. Weidert*

or by *me*

Registered Apprentice No. ...., working under my personal supervision. *Weidert mrd co*

Signed *John A. Weidert*

Licensed Embalmer No. *2238*

(Bot 389) P. O. Address *Farmington M*

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.