

REC'D JUL 10 1939

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

21286
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 1 Registration District No. 399
(b) Township Wm Primary Registration District No. 1002
(c) City W E mo (d) Street No. W E Gen Hosp Registered No. 2554
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(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 Ben Simons
(a) Residence, No. 552 County Same St. (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) Widowed
5A. ~~MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF Mrs. Mary Simons
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb - 23 - 1871
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
68 3 29
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor
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) Mich 1
13. NAME Wm Simons 4
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England 5
15. MAIDEN NAME Elizabeth Goudy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
17. INFORMANT Bro. H. Simons
(ADDRESS) Wichita, Kas
18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn Cem DATE 6/24/39 19
19. FUNERAL DIRECTOR (NAME) H. J. Matthews
(ADDRESS) W. E. Gen Hosp
20. FILED 6/24 39 M. M. Crow
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-22-39, 19
22. I HEREBY CERTIFY, That I attended deceased from 6-1-39 19, to 6-22-39 19.
I last saw him alive on 6-22-39 19. Death is said to have occurred on the date stated above, at 11:30 a.m.
The principal cause of death and related causes of importance were as follows:
Paralysis left leg.
(Arterio sclerosis)
(non diabetic)
Tubercula
Date of onset
Other contributory causes of importance:
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? yes
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? yes
If so, specify
(Signed) W. E. Gen Hosp M. D.
(Address) W. E. Gen Hosp

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.

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 *P. E. Snow*

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

Signed *W. M. Ayberry*

Licensed Embalmer No. *9934*

P. O. Address *H. C. 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.