

1939 AUG 11 1939

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

Do not use this space.

1. PLACE OF DEATH

County Shelby
Township Bethel
City Bethel (No. _____)

Registration District No. 1024
Primary Registration District No. 4499

File No. 27003
Registered No. _____
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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 4 1939

22. I HEREBY CERTIFY, That I attended deceased from April 1 1939, to July 4 1939

I last saw h. or w. alive on July 8 1939 Death is said to have occurred on the date stated above, at 7:00 p.m.

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

Septic gall bladder Date of onset _____

Other contributory causes of importance: Following operation:

Name of operation drainage of gall bladder Date of May 20
What test confirmed diagnosis? Dr. Gray Was there an autopsy? No

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. L. Simpson M.D.

(Address) Shelby Co. Mo.?

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John B. Simpson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4 - 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 0 0 1

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife

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) Illinois

13. NAME Not known

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

15. MAIDEN NAME Not known

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

17. INFORMANT Louis Simpson (ADDRESS) Bethel Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Not known DATE July 6 1939

19. UNDERTAKER (ADDRESS) McClain & Barkley Shelby Co. Mo.

20. FILED July 5 1939 Mrs. C. W. Mearns Registrar.

127

RECEIVED

District Health Officer No. 10

District File Number 8-39-1363

Date Filed AUG 4 1959

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

27003

Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Registration District No. 1024
(b) Township _____ Primary Registration District No. 4499 Registered No. _____
(c) City Bethel (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

Ella 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 Wid

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.
70 0 0

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) 7-4 1939

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:

Septic Gall bladder Date of onset _____

Other contributory causes of importance:

Following operation for Cholelithiasis

Name of operator Drainage of Gall Bladder 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) S. L. Simpson M.D.
(Address) Shelby

1939

S-27003