

REC'D SEP 12 1939

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

29182
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
(b) Township _____ Primary Registration District No. 2001
(c) City SPRINGFIELD (d) Street No. St. John Hosp. 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 Aurelia F. Simon

(a) Residence, No. 640 S. Campbell 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H.C. Simon
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 1, 1865
7. AGE YEARS 74 MONTHS 45 DAYS 27 IF LESS than 1 day, hrs. or min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 28, 1939
22. I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1939, to Aug. 28, 1939
I last saw h. alive on Aug. 27, 1939. Death is said to have occurred on the date stated above, at 5.28 a.m.
The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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.

Cerebral Thrombosis Date of onset 2-3-29
Stroke

12. BIRTHPLACE (CITY OR TOWN) Champaign (STATE OR COUNTRY) Illinois

Other contributory causes of importance:
Acute Cardiac failure Aug 21
Hypertension

FATHER 13. NAME Harvey Hawkins

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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

MOTHER 15. MAIDEN NAME Louisa Roe

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)

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

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT Victor Simon (ADDRESS) Springfield, Mo.

Manner of injury _____
Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE New London, Mo. DATE Aug. 30, 1939

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) J.B. Camp, M. D.

19. FUNERAL DIRECTOR (NAME) H.H. Lohmeyer (ADDRESS) Springfield, Mo.

20. FILED Aug 29, 1939 Chas. A. George Local Registrar. 290 (Address) Springfield, Mo.

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.....
....., 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 con
with the above constitutes grounds for revocation of license.)**

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

X