

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39863

Registration District No. 398

Primary Registration District No. 5554

Registrar's No. 553

1. PLACE OF DEATH:

(a) County Jackson (b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2006 Vermont 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME Faul Jackson Sims

8. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
(b) Name of husband or wife Israh E 6. (c) Age of husband or wife if alive 6 years
7. Birth date of deceased July 6 1859 (Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 20 If less than one day hr. min.

9. Birthplace Un Known (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature P. D. Sims

(b) Address 2006 Vermont Indip Mo

17. (a) Burial (b) Date thereof 11-28-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains Mo

18. (a) Signature of funeral director George W. Beck

(b) Address Independence Mo

19. (a) 12-5-39 (b) P. D. Leach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town West Plains (If outside city or town limits, write "RURAL")
(d) Street No. Woodland Ave (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1939 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from Nov 14, 39
19 to Nov. 25, 1939;
that I last saw him alive on Nov 25, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy
RT side hemiplegia

Due to Senility

Due to Senility

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations Senility

Of autopsy Senility

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Senility
(b) Date of occurrence Nov 26, 39
(c) Where did injury occur? Senility (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Senility

While at work? Senility (Specify type of place) (a) Manner of injury Senility

28. Signature George W. Beck (M. D. or other) 1
Address 11027 W. 11th St. Indip Mo Date signed 11-26-39

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.