

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. 40162

Registration District No. 106

Primary Registration District No. 1671

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
 (b) City or town Baker Township (rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Henrietta Simpson 512
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife William S. Simpson 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 8, 1864
 (Month) (Day) (Year)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
 (c) City or town Baker Township (rural)
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7 miles east of Pardin
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
 year 1939 hour 12 minute 15 P. M.
 21. I hereby certify that I attended the deceased from Jan 6, 1925
 _____, 19____, to Nov 20, 1939
 that I last saw her alive on Nov. 20, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
 Due to Myopathy SH
 Due to _____
 Other conditions Diabetes Mellitus
 (Include pregnancy within 3 months of death)

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury 3
 23. Signature Gelbert H. Kroeger M. D. or other DO
 Address Pocahontas Date signed 11-20-39

MOTHER FATHER
 12. Name James Inglis 4
 13. Birthplace _____
 (City, town, or county) (State or foreign country) Scotland
 14. Maiden name Matilda Smith
 15. Birthplace Knoxville Tenn
 (City, town, or county) (State or foreign country)
 16. (a) Informant's own signature Mrs. W. J. Thudium
 (b) Address New Boston Mo
 17. (a) Burial (b) Date thereof Nov. 22-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Bear Branch Church
 18. (a) Signature of funeral director Rusk Funeral Home
 (b) Address 418 Linn, Brookfield, Mo 64511
 19. (a) Nov 23-1939 (b) Deatonde Williams
 (Date received local registrar) (Registrar's signature)

1239-1745

DEC 15 1933

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 H. B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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.