

Registration District No. 431Primary Registration District No. 2002

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Jasper  
 (b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. John's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 In this community 4 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Calvin Clark Simonson 563

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 6 1935  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
4 2 28 hr. \_\_\_\_\_ min.9. Birthplace Syracuse Kansas  
(City, town, or county) (State or foreign country)10. Usual occupation Child

## 11. Industry or business \_\_\_\_\_

12. Name Lee Roy Simonson13. Birthplace Cunningham Kansas  
(City, town, or county) (State or foreign country)14. Maiden name Mildred Boyd15. Birthplace Johnson Kansas  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mildred Simonson(b) Address 315 So. Maple, Joplin, MO17. (a) Burial (b) Date thereof 3-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Osborne Cemetery18. (a) Signature of funeral director Reynolds Mortuary(b) Address Joplin, Missouri19. (a) 3-7-40 (b) Ed E. James  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Jasper  
 (c) City or town Joplin  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 315 South Maple  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th  
year 1940 hour 5:15 minute a M.21. I hereby certify that I attended the deceased from March 1st 1940, to March 3rd 1940  
that I last saw him alive on March 3rd 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Bronchial pneumonia. Duration \_\_\_\_\_Due to infection

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations Of autopsy 

## PHYSICIAN

Underline the cause to which death should be charged statistically

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

(a) Accident, suicide, or homicide (specify) no(b) Date of occurrence no

(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? no

377 (Specify type of place) While at work (e) Means of injury

23. Signature Ed E. James (M. D. certifier)Address 616 Tuscumbia Bldg Date signed 3-7-40

RECEIVED

Health Officer No. 6,  
Number 440-1023  
Date Filed APR 10 1940

107W

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 F. M. Jones  
Licensed Embalmer No. 2319  
P. O. Address Johns River

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11318<sup>7</sup>

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Capitan  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(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.** Calvin Clark Simonson  
**3. (b) If veteran,** name war \_\_\_\_\_  
**3. (c) Social Security** No. \_\_\_\_\_

**4. Sex** m **5. Color or race** w  
**6. (a) Single, widowed, married, divorced** s  
**6. (b) Name of husband or wife** \_\_\_\_\_  
**6. (c) Age of husband, or wife, if alive** \_\_\_\_\_ year

**7. Birth date of deceased**  
(Month) (Day) (Year)

**8. AGE:**  
 Years 4 Months 2 Days 28  
If less than one day \_\_\_\_\_ h. \_\_\_\_\_ min.

**9. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

**10. Usual occupation** \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_

**12. Name** \_\_\_\_\_

**13. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

**14. Maiden name** \_\_\_\_\_

**15. Birthplace** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

**16. (a) Informant** \_\_\_\_\_

**(b) Address** \_\_\_\_\_

**17. (a)** \_\_\_\_\_ **(b) Date thereof** \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** \_\_\_\_\_

**18. (a) Signature of funeral director** \_\_\_\_\_

**(b) Address** \_\_\_\_\_

**19. (a)** \_\_\_\_\_ **(b)** \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**20. DATE OF DEATH** Month Mar day 4  
 year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above  
 Immediate cause of death Bronchial pneumonia

Due to Infection  
Chronic nephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

**23. Signature** C. V. Outh (M. D. \_\_\_\_\_)

Address 616 Frisco Bldg Date signed 7-20-46

SUPPLEMENTAL

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

R

11318 (1946)