

SEP 24 1940

STANDARD CERTIFICATE OF DEATH

State File No. 27813

Registration District No. 11

Primary Registration District No. 2014

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Andrew
 (b) City or town Clay township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: J
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 71 yrs years, months or days

3. (a) PRINT FULL NAME Martha Simmerly 564

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 Single

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

7. Birth date of deceased 5 13 - 1869
 (Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Fillmore MO.
 (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER
 12. Name Frank Simmerly
 13. Birthplace un known 4
 (City, town, or county) (State or foreign country)

14. Maiden name Rachael Lance
 15. Birthplace un known Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ray M. Blaskey
 (b) Address: Fillmore Mo.

17. (a) Burial (b) Date thereof 8-12-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Fillmore

18. (a) Signature of funeral director E. C. Breit
 (b) Address Savannah MO/

19. (a) Aug 12 - 40 (b) Mrs. Addie Barnes
 (Date received local registrar) (Registar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
 (c) City or town Clay township
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 10
 year 1940 hour 10 minute 10 p. a. M.

21. I hereby certify that I attended the deceased from July 27
 _____, 1940, to Aug 10, 1940;
 that I last saw him alive on Aug 7, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Paraplegia Duration 14 days

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy none

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) _____
 (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 E. L. Morgan (M. D. or other) _____

Address Graham, Mo Date signed 8/12/40

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should list CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X19311

RECEIVED

District Health Officer No. 11

District File Number

Date Filed

827

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27813**
Registrar's No. **38**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **11**

Primary Registration District No. **3014**

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

1. PLACE OF DEATH:

(a) County Gordon T. Co.

(b) City Clayton T. Co.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew

(c) City or town Rural
(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.

3. (a) PRINT FULL NAME Martha Simmerly

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 71 Months 2 Days 27 If less than one day _____ 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 10
year _____ 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 Paralysis

Due to cerebral hemorrhage 10 days

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? no (Specify type of place) _____

(e) Means of injury _____

23. Signature E. S. Morgan (M. D. or other) _____

Address Graham Mo Date signed 9/11/50

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

