FILED FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1249

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 209

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital No. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-29-40-1-10-41 (Specify whether

In this community 23 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 1620 Paseo (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Delbert Simons

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jackie Simons

6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased January 16, 1872 (Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 24 If less than one day ..... hr. ..... min.

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

10. Usual occupation W.P.A.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital # 2

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 15 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Mound City Kans.

18. (a) Signature of funeral director Irving & McCoy

(b) Address 1513 Troost

19. (a) Jan 14, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 10 year 41 hour 1 minute 20 A. M.

21. I hereby certify that I attended the deceased from 12-29- , 1940 to 1-10- , 1941; that I last saw him alive on 1-10- , 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypertensive Type of Heart Disease.	
Due to Hypertension 93 D	
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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Gen. Hosp. #2 Date signed 1-11-41

(Licensed Embalmer's Statement on Reverse Side)

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 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 [illegible] Harris. Sr

Licensed Embalmer No. 3388

P. O. Address K. C. 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.