

FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26483

Do not use this space. 115

1. PLACE OF DEATH

(a) County North Registration District No. 903
 (b) Township Stoddard Primary Registration District No. 45-45
 (c) City Grant City (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Carrie Adaline Simmons
 (a) Residence, No. Grant City Mo. St. Resident
 (Usual place of abode, if no street address, give county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED <u>Widow of Samuel Simmons</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>7 8 " 9 23 1915</u>		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day: _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Housewife</u>	
	10. Date deceased last worked at this occupation (month and year) <u>1915</u>	
	11. Total time (years) spent in this occupation <u>24</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Jefferson County Wisconsin</u>		
FATHER	13. NAME <u>Mervin M. Wakeman</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Michigan</u>	
MOTHER	15. MAIDEN NAME <u>Caroline Stoddard</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Michigan</u>	
17. INFORMANT (ADDRESS) <u>Cyberia Wells Grant City</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Grant City Mo.</u> DATE <u>May 25, 1941</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>John Anderson Grant City Mo.</u>		
20. FILED <u>July 15, 1941</u> <u>Clifford Adams</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22, 1941

22. I HEREBY CERTIFY, That I attended deceased from June 6, 1939, to May 22, 1941
 I last saw her alive on May 21, 1941. Death is said to have occurred on the date stated above, at 5 m.
 The principal cause of death and related causes of importance were as follows:
myocarditis followed by cerebral hemorrhage
 Date of onset _____
 Other contributory causes of importance 43A

Name of operation _____ Date of _____
 What test confirmed diagnosis? yes Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury None
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) John Anderson M. D.
 (Address) Grant City

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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.

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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.....

John Andrews
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
John Andrews
Licensed Embalmer No..... *3285*

P. O. Address *Grant City*

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.