

S. No. 2
-1-4-41
5-17-39
P-1 X26390

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34655**

Registrar's No. **143**

Registration District No. **198**

Primary Registration District No. **3011**

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 days
In this community 2 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2932 Charlotte
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Samuel Simmons

3. (b) If veteran, name war World War
3. (c) Social Security No. Yes-Not Remembered

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

6. (b) Name of husband or wife Nollie Simmons
6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Sept. 25, 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>0</u>	<u>7</u>hr.min.

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

10. Usual occupation Salesman

11. Industry or business Hardware & Furniture

12. Name Jonathan Simmons

13. Birthplace ? Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Lvda B. Bitmer

15. Birthplace ? Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Admin

(b) Address istration, Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 10-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheridan, Mo.

18. (a) Signature of funeral director Claude Prichard

(b) Address CLAUDE PRICHARD

19. (a) 10-6-41 (b) Mrs. R. Bucken
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3d
year 1941 hour 3:05 minute P M.

21. I hereby certify that I attended the deceased from September 9 19 41 October 3 19 41
that I last saw h. im alive on October 3 19 41
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma, bronchogenic, left lung, with secondary abscess

Due to.....

Due to.....

Other conditions H7d
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy No 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 N.J. DOLAN, M.D. (M. D. or other)

Address Veterans Administration, Excelsior Springs, Mo. Date signed 10-4-41

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

MCC

180

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 11-12-41

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

Robert Ray

Licensed Embalmer No.

4182

P. O. Address

Excelsior Springs, 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, fact should be so stated above.