

No. 2
-1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7234

State File No.

Registrar's No. 1

Registration District No. 5-39

Primary Registration District No. 4320

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

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Marquand
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Bonne Terre (b) County St. Francois
(c) City or town Mineau
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME CHARLES FRANKLIN SIMMONS

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 married
6. (b) Name of husband or wife Libbie Queen Simmons 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased march 24 1857
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 6 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business.....

MOTHER FATHER { 12. Name Franklin Simmons
13. Birthplace CANY - SAY R
(City, town, or county) (State or foreign country)
14. Maiden name Hanna Harder
15. Birthplace CANY - SAY R
(City, town, or county) (State or foreign country)

16. (a) Informant Lizzie OWENS

(b) Address MARQUAND MO

17. (a) Burial (b) Date thereof 1-2-72
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Mo

18. (a) Signature of funeral director Wm. B. Barber

(b) Address Marquand, Mo.

19. (a) Jan 2 - 1942 (b) B. A. S. Claughton
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 15
year 1942 hour 12 AM, minute..... M.

21. I hereby certify that I attended the deceased from Jan 19 - 1942
to Jan 1 - 1942
that I last saw him alive on Jan 19 - 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Poisoning Wound
Duration.....

Due to.....

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 2

(c) Where did injury occur? 2
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
2

While at work? 2 (Specify type of place) (e) Means of injury 2

23. Signature W. B. Barber (M. D. or other)
Address Fredericktown, Mo. Date signed 1/19/42

(Licensed Embalmer's Statement on Reverse Side)

(BARBER)

RECEIVED

District Health Officer No. 4
District File Number 243-666
Date Filed 2-16-83

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7234
Registrar's No.

Registration District No. 539

Primary Registration District No. 4320

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

1. PLACE OF DEATH

(a) County Madison
 (b) City or town Marquand
 (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 Charles F. Simmons
 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 m

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

7. Birth date of deceased Mar 24
 (Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 6 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)

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1942 hour _____
 21. I hereby certify that I attended the deceased from _____
 that he or she was _____ alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Duration _____

Premie Poisoning
enlarged prostate gland
and narrowing of
the lumen of the
urethra

Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings _____
 Of operation _____
 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)
 (b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (c) Means of injury _____

23. Signature M. B. Barber (M. D. or other) _____
 Address Fredericktown Date signed 1/30/42

SUPPLEMENTAL

MOTHER FATHER

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

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