

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15900

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAY 23 1942  
90.3

4545

1. PLACE OF DEATH:

- (a) County Worth  
(b) City or town Grant City, Mo.  
(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 (Specify whether)  
In this community 30 years  
years, months or days

3. (a) PRINT FULL NAME Delph C. Simons

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

7. Birth date of deceased December 8, 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 4 9 hr. min.

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

10. Usual occupation editor

11. Industry or business

12. Name James M. Simons  
13. Birthplace Taylor Co., Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Della G. Mitchell  
15. Birthplace Boone Co., Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant James M. Simons  
(b) Address Grant City, Mo.

17. (a) burial (b) Date thereof 4-19-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director Arch C. Duff

- (b) Address Grant City, Mo.

19. (a) April 21, 1942 (b) Arlene Swadlow  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Worth  
(c) City or town Grant City  
(If outside city or town limit, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17  
year 1942 hour 5 minute A.M.

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

- Immediate cause of death Cerebral Hemorrhage  
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)  
(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 Bertie Neal (M. D. or other)

- Address Grant City Date signed 4/18/42

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

1104

(Licensed Embalmer's Statement on Reverse Side)

FEB 16 1934

**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

*Arch C. Duffee*

Licensed Embalmer No.

*3252*

P. O. Address

*Grant City, 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.**