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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUL 20 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21925

Registration District No. 636 Primary Registration District No. 5844 Registrar's No. 22

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Piney Twsp. Rural
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Oregon 75
(c) City or town Alton (Rural) 0
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Peter C. Simpson
3. (b) If veteran, name war --
3. (c) Social Security No. --
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mattie F. Ross
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Oct. 7 1861 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
80	-	5	hr. min.

9. Birthplace Oregon County (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER 12. Name Wade Simpson
13. Birthplace (City, town, or county) Unknown 9 (State or foreign country)
MOTHER 14. Maiden name Eliza Gum
15. Birthplace (City, town, or county) Unknown 9 (State or foreign country)
16. (a) Informant C. C. Simpson
(b) Address Alton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/41 (Month) (Day) (Year)
(c) Place: burial or cremation Hall Cem.
18. (a) Signature of funeral director Reo Carr
(b) Address Thayer, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12 year 1941 hour 12:17 minute P. M.
21. I hereby certify that I attended the deceased from December The 11 1940 to Oct 12 1941; that I last saw him alive on Oct The 8 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Senility	
T Brights Disease	
Due to Exposure	
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 0
23. Signature G. B. Forest (M. D. MD)
Address Alton Mo Date signed 10/15/41

1113 (Licensed Embalmer's Statement on Reverse Side) G. B. Forest

RECEIVED
District Health Officer No. 5,
District File Number [redacted]
Date Filed _____

RECEIVED
District Health Officer No. 5,
District File Number 242269
Date Filed 7-17-42

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21925

Registration District No. 636 Primary Registration District No. 5844 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME Peter C. Simpson

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 Mattie

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

7. Birth date of deceased Oct (Month) 7 (Day) 1861 (Year)

8. AGE: Years 80 Months — Days If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

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

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

16. (a) Informant C C Simpson
(b) Address Alton Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Hall Cem

18. (a) Signature of funeral director Lee Carr
(b) Address Thayer Mo

19. (a) 11/14 1941 (Date received local registrar) (b) Enoch Bailey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1941 hour minute M.

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

Immediate cause of death Sterility and Bright disease

Due to Exposure

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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

1316

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 G B Forest (M. D. or other)
Address Alton Mo Date signed