

FILED MAR 8 1943

Registration District No. 165

Primary Registration District No. 5602

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Johnson Rural  
(b) City or town Blainstown (Cheltenham) Mo  
(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 25 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson  
(c) City or town Blainstown (Rural Cheltenham) Mo  
(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 John Wm. 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 married

6. (b) Name of husband or wife Addie Simons 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Sep-9-1871 (Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Chas. W. Simons

13. Birthplace Cooper Co. Mo (City, town or county) (State or foreign country)

14. Maiden name Arnolda Brown

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

16. (a) Informant Mrs. John W. Simons

(b) Address Blainstown, Mo

17. (a) Burial (b) Date thereof Feb-2-1943 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spruce Hill

18. (a) Signature of funeral director Queeney - Phyllis

(b) Address Warrensburg, Mo

19. (a) 2-2-43 (b) M. D. L. Cook (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan - day 31 year 1943 hour 5:30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from June 2, 1940 to Jan 31, 1943 that I last saw him alive on Jan 14, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Hypertensive Cardiac  
Vascular disease

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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)  
(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 Phyllis Queeney (M. D. or other) \_\_\_\_\_  
Address Warrensburg, Mo Date signed 2/2/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

51  
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RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 3-5-43

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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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed S. B. Sweeney

Licensed Embalmer No. 1127

P. O. Address Warrenburg

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.