U. S. No. 2
10M—5-42
Rev. 5-17-39
P-I X-2574

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 7 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

D-K

State File No. 10703

Registration District No. 172 | Primary Registration District No. 3034 | Registrar's No. 18

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1. PLACE OF DEATH:
(a) County: Lafayette
(b) City or town: Higginsville. 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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Lafayette
(c) City or town: Higginsville.
(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: 0

3. (a) PRINT FULL NAME: Mary Allan Simpson
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widowed.
6. (b) Name of husband or wife: Peter Simpson
6. (c) Age of husband or wife if alive: Dead years
7. Birth date of deceased: Feb- (Month) 2- (Day) 1861 (Year)

8. AGE: Years 82 | Months 0 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace: Scotland (City, town, or county) / (State or foreign country)
10. Usual occupation: House keeper
11. Industry or business: Don't know

MOTHER FATHER
12. Name: Don't know
13. Birthplace: Scotland (City, town, or county) / (State or foreign country)
14. Maiden name: Don't know
15. Birthplace: Scotland (City, town, or county) / (State or foreign country)

16. (a) Informant: James Simpson
(b) Address: Higginsville. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-19-43 (Month) (Day) (Year)
(c) Place: burial or cremation: City. C. Higginsville
18. (a) Signature of funeral director: Alfred H. Harris
(b) Address: Higginsville. Mo.
19. (a) 3-10-1943 (Date received local registrar) (b) Dr. W. A. Braeckleim (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb- day 17th year 1943 hour 9 minute 45 M.
21. I hereby certify that I attended the deceased from ..... 19 32 to Feb 17 19 43
that I last saw him alive on Feb 17 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Valvular disease over 10 yrs. — Duration
Due to: .....
Due to: .....
Other conditions (Include pregnancy within 3 months of death): 9 d
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: .....

23. Signature: W. F. Kopperud (M. D. or other) MD
Address: Higginsville Mo. Date signed: 2/22/43

(Licensed Embalmer's Statement on Reverse Side)

EIVED
...ict Health Officer No. 8,
District File Number
Date Filed 4-5-43

NOV 20 1944

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 ~~336 Me~~ Forrest . Hoefer, Registered Apprentice No. 336, working under my personal supervision.

Signed Alfred H Hoefer

Licensed Embalmer No. 539

P. O. Address Higginsville, 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.