

S. No. 2
M-2-43
17-39
X3587

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

28973

ED AUG 23 1943

Registration District No. 271

Primary Registration District No. 594 4401

Registrar's No.

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Pascola, Missouri
(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 Missouri (b) County Pemiscot
(c) City or town Pascola, Missouri
(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 Albert Sidney Simpson

3. (b) If veteran, name war World War #1 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Gladys Simpson 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased August 4, 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 6 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Bill H. Simpson
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Francis Lee
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Gladys Simpson
(b) Address Pascola, Missouri

17. (a) Burial (b) Date thereof Aug. 12, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Cemetery

18. (a) Signature of funeral director L. P. Denton
(b) Address Caruthersville, Mo.

19. (a) Aug 20-43 Mrs J. P. Cole
(Date registered local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10
year 1943 hour 1 minute 30 P. M.
21. I hereby certify that I attended the deceased from Aug 10th 1943
10th 1943 to Aug 10th 1943
that I last saw him alive on 8/10/43
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Pulmonary Hemorrhage
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) None

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) (c) Means of injury _____
23. Signature L. P. Denton (M. D. or other) MD
Address Hayti, Mo Date signed 8/11/43

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

5911

JUL 9 1966

8701 73 210V

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 *H. Smith*

Registered Apprentice No. _____

working under my personal supervision.

Signed *H. Smith*

Licensed Embalmer No. *3900*

P. O. Address *Caruthersville*

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.

Registration District No. 211

Primary Registration District No. 4401

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

1. PLACE OF DEATH

(a) County Pemiscot
(b) City or town Pascola
(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

Albert S. Simpson

3. (b) If veteran name war W.W.I 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Aug. 4 1904
(Month) (Day) (Year)

8. AGE: Years 48 Months _____ Days _____ 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) 8-20-43 (b) Mrs T. P. Cole
(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 Aug Day 20 Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that the death occurred on the date and hour stated above. Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

28973