

Registration District No. 381

Primary Registration District No. 4513

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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 1
years, months or days (Specify whether
In this community 40 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(c) City or town Milan 10.5
(If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years. ?

3. (a) PRINT FULL NAME

Dora Belle Simpson

3. (b) If veteran, name war. _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct., day 25
year 1943 hour 9 minute 20 P. M.

21. I hereby certify that I attended the deceased from Oct. 21, 1943 to Oct. 25, 1943
that I last saw her alive on Oct. 25, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death coronary thrombosis
Duration 5 da.

5. Color or race white 6. (a) Single, widowed, married, divorced married

4. Sex Female 6. (b) Age of husband or wife if 71 years

6. Name of husband or wife Smith Howard Simpson

7. Birth date of deceased October 20 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>0</u>	<u>5</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name James G. Shelton

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

14. Maiden name Sullivan

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

16. (a) Informant S. H. Simpson

(b) Address Milan, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem. Milan

18. (a) Signature of funeral director Schoenberg

(b) Address Milan Mo Frankl.

19. (a) Nov. 5-43 (Date received local registrar) (b) Mrs. B. D. Sheon (Registrar's signature)

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 _____

Where did injury occur? _____ (City or town) (County) (State)

(c) 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 Carl Simpson (M. D. or other) _____
Address Milan Date signed 10-26-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

05
1
0

NOV 17 1943

APR 20 1945

RECEIVED

District Health Officer No. 10

District File Number 11-43-1809

Date Filed NOV 12 1943

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 Frank D. Schaefer

Licensed Embalmer No. 2116

P. O. Address Milan, 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.