

FILED JAN 10 1944

Registration District No. _____

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Henkeville
(c) Name of hospital or institution: Community Hospital
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 10 days
(Specify whether in this community 15 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Henkeville
(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

Joseph M. Simmons

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 1
6. (b) Name of husband or wife Phyllis Simmons 6. (c) Age of husband or wife if alive yes years
7. Birth date of deceased Dec 2 1968
(Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 13 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name George Simmons
13. Birthplace Eng 11
(City, town, or county) (State or foreign country)
14. Maiden name Ann Patton
15. Birthplace Eng 14
(City, town, or county) (State or foreign country)

16. (a) Informant Phyllis Simmons

(b) Address Yassaw, Mo

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

(c) Place: burial or cremation Union Temple

18. (a) Signature of funeral director O. H. Nopp

(b) Address Salamanca, Mo

19. (a) 12/21/43 (b) Dr. J. P. Wayne
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3 of month _____
year 1943 hour 7:30 minute 20 A. M.

21. I hereby certify that I attended the deceased from December 3 of the 1943 to December 15, 1943, that I last saw him alive on December 14, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage

Due to Carcinoma of Lung

Due to 478

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

Major findings: Of operations No operation

Of autopsy No 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 A. R. Schrey (M.D. or other) _____
Address Community Hospital Date signed 12/15/43

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

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

RECEIVED

District Health Officer No. 70

District File Number 1-4-12

Date Filed JAN 7 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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4760

P. O. Address Blauvelt

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.