

No. 1-2-43  
5-17-39  
X35897

**FILED FEB 11 1944**

Registration District No. **1**

Primary Registration District No. **5797**

Registrar's No. **1771**

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

**1. PLACE OF DEATH:**

(a) County **Carroll**  
(b) City or town **Rural**  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community **Many years**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Carroll**  
(c) City or town **Rural**  
(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** **Florence Simms**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Fe** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Walter Simms** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **June 15 1865**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **6** Days **17** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **At Home**

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

12. Name **J. R. M. Coubric**

13. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Cleve M. Coubric**

(b) Address **Carrollton Mo.**

17. (a) **Burial** (b) Date thereof **1-3-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Williamslem**

18. (a) Signature of funeral director **Stanley**

(b) Address **Carrollton Mo.**

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Jan** day **1** year **1944** hour **2** minute **00 P.** M.

21. I hereby certify that I attended the deceased from **Dec-26-1943** to **Jan 1 1944**  
that I last saw her alive on **Jan 1 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death **pneumonia (Bronchial)**  
Due to **Influenza**  
Duration **7 days**

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

Major findings: Of operations **33a**  
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 **C**

23. Signature **Stella Kelling M.D.**  
Address **Laverly, Mo.** Date signed **Jan 2 1944**

RECEIVED

District Health Officer No. 87

District File Number 2-8-11

Date Filed 2-8-11

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.

FILED FEB 1

Registration District No. 5-d

Primary Registration District No. 5197

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Small Sugar Tree Twp  
(b) City or town Rural  
(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 Florence Simms

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased June 15 1888  
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace Ohio  
(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) 11-3-1944 (b) Max James Rafferty  
(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 \_\_\_\_\_ day \_\_\_\_\_  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

2434