

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 42

1. PLACE OF DEATH:

(a) County PETTIS
 (b) City or town SEDALIA
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution BOTHWELL HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 23 DAYS
 (Specify whether
 In this community IN BENTON Co. Mo 45 YEARS
 years, months or days)

3. (a) PRINT
 FULL NAME

MATTIE SIMS

3. (b) If veteran,
 name war _____

3. (c) Social Security
 No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 (Month) (Day) (Year)

7. Birth date of deceased 2 27 1874
 (Month) (Day) (Year)
 8. AGE: Years Months Days If less than one day
69 11 3 hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name CHRISTIAN LEHMAN
 13. Birthplace BERN SWITZERLAND
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace BERN SWITZERLAND
 (City, town, or county) (State or foreign country)

16. (a) Informant CARL SIMS
 (b) Address GREEN RIDGE, Mo.

17. (a) BURIAL (b) Date thereof 2-1-1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LINCOLN Mo. CEMETERY

18. (a) Signature of funeral director JACK CALBERT

(b) Address LINCOLN Mo.

19. (a) 1/31/44 (b) Mrs. Anna Berger
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PETTIS
 (c) City or town GREEN RIDGE
 (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 JAN day 30
 year 1944 hour 2.10 P minute _____ M.

21. I hereby certify that I attended the deceased from January 8
 19 44 to Jan 30 19 44
 that I last saw h. er alive on January 30 19 44
 and that death occurred on the date and hour stated above.

Immediate cause of death End-arteriosclerosis Obstructive
General Septicemia
 Duration 8 1/2 mos
3 days

Due to _____
 Due to _____

Other conditions Varicose Veins
 (Include pregnancy within 3 months of death)

Major findings: None 9912 PHYSICIAN
 Of operations _____
 Of autopsy None
 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) None
 (b) Date of occurrence None
 (c) Where did injury occur? None
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
None

While at work? _____ (Specify type of place)
 (e) Means of injury 0

23. Signature John D. Calbert M.D. (M. D. or other)
 Address Sedalia Mo Date signed 1/31/44

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 3-7-47

OCT 1 1947

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 Geo Dillard
Licensed Embalmer No. 3868
P. O. Address Sudalia

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.