

**FILED MAR 25 1944**

Registration District No. \_\_\_\_\_

Primary Registration District No. 3006

Registrar's No. 39

1. PLACE OF DEATH:  
(a) County. Boone  
(b) City or town. Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
511 Turner Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether)  
In this community 37 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. Missouri (b) County. Boone  
(c) City or town. Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 511 Turner  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SILAS TRUMAN SIMPSON  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 19 year 1944 hour 7:00 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from Feb. 18 1944 to Feb. 19 1944 that I last saw him alive on Feb. 19 and that death occurred on the date and hour stated above.

4. Sex. Male 5. Color or Race. White 6. (a) Single, widowed, married, divorced. Married  
6. (b) Name of husband or wife. Mildred Norris Simpson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. 12 - 18 - 1886  
(Month) (Day) (Year)

Immediate cause of death. Myocarditis chronic chronic coronary disease  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
57 2 1 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Amesotropic Sclerotic Sclerosis ?  
(Include pregnancy within 3 months of death) (Sclerosis)

9. Birthplace. Worth County Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation. Cattle Specialist

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name George Porter Simpson  
13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Cornelia Salmon  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Mrs. S.T. Simpson  
(b) Address 511 Turner, Columbia, Mo.  
17. (a) Burial (b) Date thereof 2-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Columbia Cemetery  
18. (a) Signature of funeral director Allen Funeral Service  
Columbia, Mo.  
(b) Address \_\_\_\_\_  
19. (a) 2-20-44 (b) E. Howard Barber  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Frank E. Pedersen (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 2-21-44

1250

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**RECEIVED**  
**District Health Officer No. 9,**

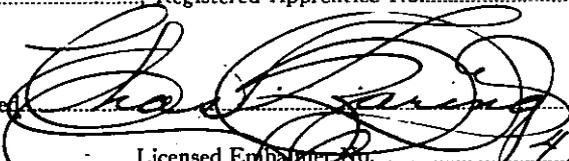
District File Number \_\_\_\_\_  
Date Filed 3-22-44

**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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed  \_\_\_\_\_  
Licensed Embalmer No. 413  
P. O. Address Shusabie,

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**