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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 23 1944**  
54

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10602

State File No. ....

Registration District No. ....

Primary Registration District No. 4077

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)

(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 9 years  
years, months or days

3. (a) PRINT FULL NAME JASPER NEWTON SIMMONS

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

4. Sex MALE 5. Color or race White

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LORA SIMMONS 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased Feb 6 1885  
(Month) (Day) (Year)

8. AGE: Years 79 Months - Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace BURFORDVILLE Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

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 ARTHUR SIMMONS

(b) Address ST LOUIS MO

17. (a) BURIAL (b) Date thereof FEB 21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MCQUIRE CEMETERY

18. (a) Signature of funeral director DEBRAUGH FUNERAL HOME

(b) Address CAPE GIRARDEAU MO

19. (a) FEB 23, 1944 (b) A. H. Macke  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington

(c) City or town Whitewater  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB 19 day \_\_\_\_\_  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Aug 5 1943  
to FEB 19 1944 to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him alive on FEB 17, 1944  
and that death occurred on the date and hour stated above.

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

Due to myocarditis

Due to prostatitis

Due to advanced age

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

Major findings: \_\_\_\_\_

Of operations 93el

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 or on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(1) Means of injury \_\_\_\_\_ (2) Means of injury \_\_\_\_\_

23. Signature W. W. Dapault (M. D. or other) MA  
Address Altonville Mo Date signed FEB 21 1944

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1945  
Florida Death Certificate No. 4  
County of Ala. Number 344-357  
Date of Death 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.....

Not embalmed, Registered Apprentice No.....  
working under my personal supervision.

Signed Byrnau Steele

Licensed Embalmer No. 2476

P. O. Address Cape Girardeau, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *April 6*Registration District No. *54*Primary Registration District No. *4077*

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County *Cape Girardeau*  
 (b) City or town *Cape Girardeau*  
 (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 days3. (a) PRINT FULL NAME *Jasper W. Simonian*

- (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased
- Feb. 6 1901*
- 
- (Month) (Day) (Year)

8. AGE: Years
- 79*
- Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

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

## 10. Usual occupation \_\_\_\_\_

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

12. Name
- Unknown*

13. Birthplace \_\_\_\_\_
- 
- (City, town, or county) (State or foreign country)

14. Maiden name
- Unknown*

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) \_\_\_\_\_ (b)
- A. H. Maese*
- 
- (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 \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

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 \_\_\_\_\_

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

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

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

SUPPLEMENTARY

10602