

FILED MAY 8 1944
Registration District No. **89934**

Primary Registration District No. **5339**

Registrar's No. **28**

1. PLACE OF DEATH:

(a) County **Dade - Rock Prairie Twp.**
(b) City or town **Ash Grove - Mo 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 **GLEETA Ann Simmons**

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

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

7. Birth date of deceased: **March 23 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **ORA SIMMONS**

13. Birthplace **Greene Co Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **LUCILE SULLIVAN**

15. Birthplace **Dade Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ora Simmons**

(b) Address **Ash Grove Mo**

17. (a) **Burial** (b) Date thereof **4-18-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ash Grove Cem -**

18. (a) Signature of funeral director **Morris D Leiman**

(b) Address **Ash Grove Mo**

19. (a) **4/19/44** (b) **Phyllis Lack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Greene**
(c) City or town **Ash Grove "Rural" Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **17**
year **1944** hour **7** minute **30** AM

21. I hereby certify that I attended the deceased from **4-15-44**
to **4-17-44**

that I last saw her alive on **4-16-44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia**
Bilateral Duration **3 days**

Due to _____

Due to _____

Other conditions (Include pregnancy within 8 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 **Dr Charles H. Orr** (M. D. or other) **MD**

Address **Ash Grove Mo** Date signed **4/17/44**

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

MOTHER FATHER

9
6
0

107

1042

RECEIVED

District Health Officer No. 6,

District File Number 544-521

Date Filed MAY 4 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 Maude O. Morris

Licensed Embalmer No. 2053

P. O. Address Ash Grove 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.