

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

38342

Do not use this space.

FILED NOV 20 1944

1. PLACE OF DEATH

(a) County Miller Registration District No. 212
(b) Township Saline Primary Registration District No. 5780
(c) City Olean, Rural (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 90

2. PRINT FULL NAME

(a) Residence, No. 1 James Allie Simmons St. Olean Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 6, 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
72 2 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Jordan Simmons

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Mollie McDonald

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Charlie Simmons
Olean

18. BURIAL, CREMATION, OR REMOVAL PLACE Carroll Ave DATE 10-14 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. N. Stephens
Russell Stephens Mo

20. FILED 10-13 1944 W. G. Lawrence Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/12 1944

22. I HEREBY CERTIFY, That I attended deceased from 10/10 1944 to 10/12 1944

I last saw him alive on 10/11 1944 Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral meningitis Date of onset 10/9/44

Other contributory causes of importance: \$12

Name of operation _____ Date of _____
What test confirmed diagnosis? Chloroform Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) G. D. Walker M. D.

(Address) Olean Mo 10/13/44

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

Miller County Health Dep't

County File Number 44-82

Date Filed 11-6-84

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 *[Signature]*

Licensed Embalmer No. 2307

P. O. Address Russellville 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, above space should be left blank.