. S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945

Registration District No. 42

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4055

State File No. 9189

Registrar's No. 360

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town Easton Mo.
(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 years, months or days)
In this community Entire Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town Easton Mo. 11
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LENNA FRANK- SIMPSON
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 Tena Simpson
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Sept 20 1869 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
75	6	11	hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business Farmer
FATHER
12. Name William Simpson
13. Birthplace (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Leah McKinney
15. Birthplace (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Tena Simpson
(b) Address Easton Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3 45 (Month) (Day) (Year)
(c) Place: burial or cremation Flag Springs
18. (a) Signature of funeral director. H. D. Gillins
(b) Address Gower Mo
19. (a) 4-3-45 (Date received local registrar) (b) Helen J. Fickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1945 hour 11:15 minute P. M.
21. I hereby certify that I attended the deceased from Mar. 30, 1945, to Mar. 31, 1945, that I last saw him alive on Mar 31, 1945, and that death occurred on the date and hour stated above.
Immediate cause of death cerebral hemorrhage 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

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(Licensed Embalmer's Statement on Reverse Side)

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 H. A. Sullins

Licensed Embalmer No. 1738

P. O. Address Gower 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.