. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24771

FILED MAY 16 1945

Registration District No. 292 Primary Registration District No. 4434 Registrar's No.

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Center
(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 Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ralls 87
(c) City or town Center 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Jennie Lee Simpson
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 Widowed
6. (b) Name of husband or wife John A Simpson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 28 1866 (Month) (Day) (Year)
8. AGE: Years 78 Months 10 Days 24 If less than one day hr. min.
9. Birthplace Ralls CO Mo (City, town, or county) 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Own Home
MOTHER FATHER
12. Name Edwin B. Smith
13. Birthplace Ky (City, town, or county) (State or foreign country) /
MOTHER
14. Maiden name Emily Ellis
15. Birthplace Ky (City, town, or county) (State or foreign country) /
16. (a) Informant Mrs. Geo Lane
(b) Address Center, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24 45 (Month) (Day) (Year)
(c) Place: burial or cremation Center Cemetery
18. (a) Signature of funeral director Grant Green
(b) Address Center Mo
19. (a) 6/5/1945 (Date received local registrar) (b) Mrs. Earl Perkinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22 year 1945 hour 10 minute 15p M.
21. I hereby certify that I attended the deceased from May 12, 1945 to May 22, 1945 that I last saw h[illegible] alive on May 22, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis Acute	5 Days
Due to: Unknown	
Due to: Unknown	
Other conditions: None (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
Of autopsy: None	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. H. Brooke (M. D. or other) MD
Address Center Mo Date signed 6-1-45

1135

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-45-1405
Date Filed JUL 13 1945

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 Gilbert A. Hulse

Licensed Embalmer No. 4263

P. O. Address Cuttler Fla

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.