

No. 2
-5-43
-17-39
X36671

LED JUN 12 1946

Registration District No. 280

Primary Registration District No. 5878

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Alton Woodside Twsp.
(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 60 years (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75
(c) City or town Alton (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Leona Josephine 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 Thomas Jesse Simpson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 4 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Rolla Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

MOTHER FATHER

11. Industry or business _____
12. Name S. S. Morman
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Carolina Beck
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant H. J. Simpson
(b) Address Alton, Mo.

17. (a) Burial (b) Date thereof 4/21/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hall Cem
18. (a) Signature of funeral director Leo Thayer
(b) Address Thayer, Mo.

19. (a) 5-28-46 (b) msw Johnson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1946 hour 12:15 minute _____ A. M.
21. I hereby certify that I attended the deceased from 18- 1946 to April 18 1946
that I last saw him alive on Apr 18- 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Subcortical Obstruction 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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 W. H. Johnson (M. D. or other) _____
Address Waynesville, Mo. State _____
Hogans

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

RECEIVED

District Health Officer No. 5,

District File Number 646374

Date Filed 6-10-46

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.....

Licensed Embalmer No.....

P.O. Address.....

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.

Registration District No. 255

Primary Registration District No. 5878

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Alton (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 Leona J Simpson

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Jan 4 1906
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 4 (If less than one day, hr. min.)

9. Birthplace MO
(City, town or county) (State or foreign country)

10. Usual occupation _____

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 _____

(b) Address _____

17. (c) _____ (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) _____
(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 April year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ live on _____, 19____, and that death occurred on the date and hour stated above. _____
Immediate cause of death _____

Do not know; saw patient once only when in dying condition a few hours before her death.

Due to _____

Other conditions _____
(Include pregnancy within 3 months)

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 W. H. ... (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

2000

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

16436

17556