S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19244

Registration District No. 354 Primary Registration District No. 6200 Registrar's No.

1. PLACE OF DEATH:

(a) County: TEXAS

(b) City or town: RURAL MORRISTWP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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: 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Texas 107

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No.: Morris Twp
(If rural, give location) n. of Cabool

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Ivey Alfonzo Simpson

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: M

5. Color or race: W.

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Nettie

6. (c) Age of husband or wife if alive: 66 years

7. Birth date of deceased: JAN (Month) 5 (Day) 1885 (Year)

8. AGE: Years 61 Months 3 Days 29 If less than one day hr. min.

9. Birthplace: Ill. 1 (City, town, or county) (State or foreign country)

10. Usual occupation: FARMER

11. Industry or business:

MOTHER FATHER

12. Name: unknown

13. Birthplace: unknown 9 (City, town, or county) (State or foreign country)

14. Maiden name: unknown

15. Birthplace: unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Nettie Simpson

(b) Address: R# 2 Cabool Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 7, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation: Jarrett Cemetery

18. (a) Signature of funeral director: Gaylord V. Elliott

(b) Address: Cabool Mo.

19. (a) May 7 (Date received by local registrar) (b) Gaynell Cunningham (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 4 year: 9 hour: minute: P. M.

21. I hereby certify that I attended the deceased from Feb. 2, 1945 to ~~May~~ 1945 to May 1945 and that I last saw him alive on about May 3, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
Was out in yard
Carried to house

Duration

Due to:

Due to:

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 1

Of autopsy: 83N

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: J. W. Coats (M. D. or other) 5-16-46

Address: Cabool Mo Date signed

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 646369
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 Gaylord V Elliott

Licensed Embalmer No. 9252

P. O. Address Cabool 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.