

FILED JUN 2 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16871

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Excelsior Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Weeks
(Specify whether
In this community 58 Years
years, months or days)

3. (a) PRINT FULL NAME Richard Sims

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married,
divorced 9
6. (b) Name of husband or wife
6. (c) Age of husband or wife if
alive 26 years
7. Birth date of deceased Oct 26 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 6 13 hr. min.

9. Birthplace Platte County, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Plumber

11. Industry or business

12. Name Robert Sims
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Kennedy
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Sims

(b) Address Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof 5-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawson, Mo.

18. (a) Signature of funeral director Blair, Michael

(b) Address Excelsior Springs, Mo.

19. (a) 5/13/47 (b) Blair, Michael
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clay
(c) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9
year 1947 hour 10:55 minute 9 M.

21. I hereby certify that I attended the deceased from 4/9/47
to 5/9/47, 19____; and that death occurred on the date and hour stated above.
that I last saw him alive on 5/8/47, 19____;
Immediate cause of death auricular-ventricular block-

Due to myocarditis sev. years

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 Blair, Michael (M. D. or other) M. D.

Address Excelsior Springs, Mo. Date signed 5/12/47

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

RECEIVED
District Health Officer No. 8;
District File Number.....
Date Filed: 5-29-47

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, only
....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Albert E. White

Licensed Embalmer No. 4168

P. O. Address Exclusion Springs, Ma.

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.