

No. 2
12-45
17-39
47070

FILED MAY 19 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 5692

Registrar's No. 8

1. PLACE OF DEATH

(a) County Linn
(b) City or town Carson Creek Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson 979
(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL")
(d) Street No. 4205 Quipaw 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME ALLIE MAY SIMPSON

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

4. Sex Female Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Cleveland G. Simpson 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased March - 12 - 1903
(Month) (Day) (Year)

8. AGE: Years 44 Months 1 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Knox Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Pres Westfall 4

13. Birthplace Berlin Germany (City, town, or county) (State or foreign country)

14. Maiden name Ora Lee Parrish

15. Birthplace Pulledge Mo (City, town, or county) (State or foreign country)

16. (a) Informant Cleveland G. Simpson

(b) Address Kansas City, Mo.

17. (a) Burial (b) Date thereof May 5 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Millport Cemetery

18. (a) Signature of funeral director Hudson Funeral Home

(b) Address Edina Mo

19. (a) May 3 - 1947 (b) Chris A. Martens
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9
year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5-2-47
to 5-2-47, 1947

that I last saw him alive on 5-2-47, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Cervical vertebrae Duration 10 months

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy NO

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) Accident 58

(b) Date of occurrence 5-2-47

(c) Where did injury occur? Highway 36-1 M. west of
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place while driving on highway
(Specify type of place) (e) Means of injury Auto

23. Signature H. H. Foster (M. D. or other) Dr.

Address Brookfield Mo Date signed 5-3-47

Coll. with other Motor Vehicle

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

FEB 3 1949

JUL 1 1947

DEC 8 1954

SEP 1 1954

SEP 27 1954

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Keith Hudson
Licensed Embalmer No. 2413
P. O. Address Edina, Missouri

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.