

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 7 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23224

Registration District No. 374

Primary Registration District No. 4377

Registrar's No. 54

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Grant city
(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 5 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME SARAH ANGELINE 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
6. (b) Name of husband or wife John R. Simpson 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased Nov 18 1869 (Month) (Day) (Year)

8. AGE: Years 77 Months 7 Days 21 If less than one day hr. min.

9. Birthplace Grant city Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Killing & Strochar
13. Birthplace Aberdeen Scotland (City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Hagan
15. Birthplace Worth co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Stella Mogge
(b) Address Perome, Idaho

17. (a) Burial (b) Date thereof 6-27-47 (Month) (Day) (Year)

(c) Place: burial or cremation Blackstone Cemetery

18. (a) Signature of funeral director W. C. Dwyer

(b) Address Grant city, Mo.

19. (a) June 27 1947 (b) Reta E. Dawson (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Worth
(c) City or town Grant city (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 June day 25 year 1947 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from May 20 1947 to June 25 1947 that I last saw her alive on June 25 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Benign Stomach Duration 1 yr.

Due to _____

Due to H & B

Other conditions Cerebral Cerebral (Include pregnancy within 3 months of death) pro- eclamptic

Major findings: Of operations _____

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature Thasys J. D. (M. D. or other)

Address Grant city, Mo. Date signed 6-25-47

DISTRICT HEALTH OFFICE
Camden, 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.....
Arch C. Dumble

Licensed Embalmer No. *3252*

P. O. Address *Grant City, 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.