No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 13 1955

State File No. 16149

BIRTH NO. _____ REG. DIST. NO. 254 PRIMARY REG. DIST. NO. 4385 Registrar's No. 36

1. PLACE OF DEATH
a. COUNTY: Oregon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Koshkonong
c. LENGTH OF STAY (In this place): 26 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Oregon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Koshkonong 0150
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Burr
b. (Middle):
c. (Last): Simpson

4. DATE OF DEATH (Month) (Day) (Year): May 31, 1955

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 6-10-1882

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months: 11 Days: 21
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (City and State or Foreign Country): Salem, Arkansas /

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Fount Simpson

13b. MOTHER'S MAIDEN NAME: Mary Chastain

14. NAME OF HUSBAND OR WIFE: Della Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 491-18-7207

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Ida Mae Snider-Koshkonong, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 4201 — 2½ hr

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1954, 19___, *to* 1955, 19___, *that I last saw the deceased alive on* 5-30-55, 19___, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. Walker M.D.

23b. ADDRESS: Mammoth Spring Ark

23c. DATE SIGNED: 6-7-55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 2, 1955

24c. NAME OF CEMETERY OR CREMATORY: Two Mile Cemetery

24d. LOCATION (City, town, or county) (State): Thayer Oregon Missouri

DATE REC'D BY LOCAL REG.: 6-10-1955

REGISTRAR'S SIGNATURE: Arthur Wolff

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leland Carter Thayer Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed.....

Licensed Embalmer No. 4516

P. O. Address Thayer 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.