

FILED NOV 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39387

State File No.

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 171

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Peoria</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>4 days</u>	c. CITY OR TOWN <u>Princeville</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS -----		917 8	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>Roby</u>	b. (Middle) <u>T.</u>	c. (Last) <u>Simmons</u>	<u>11-19-1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-4-1885</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>15</u> Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Preston Simmons</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Blevens</u>	14. NAME OF HUSBAND OR WIFE <u>Mae Ralph Simmons</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME <u>Tom Baker, Nephew, Rt. # 1, Essex, Mo.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		ADDRESS -----

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Concussion - contusion.</u>		ANTECEDENT CAUSES		DUE TO (b) _____ DUE TO (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.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>Loss of vision, severe, face. Ruptured aneurysm, brain, L.</u>		

19a. DATE OF OPERATION <u>11/16/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Increased intracranial pressure; Atrophy brain.</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 61</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>New Madin' Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11 14 55 1:30 a.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto accident</u>

22. I hereby certify that I attended the deceased from 11-14, 1955, to 11-19, 1955, that I last saw the deceased alive on 11-19, 1955, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Hilary J. Shigmon, M.D.</u>	23b. ADDRESS <u>217 S. Kingshighway, Sikeston, Mo.</u>	23c. DATE SIGNED <u>11-19-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>11-20-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CITY</u>
24d. LOCATION (City, town, or county) (State) <u>PRINCEVILLE ILL</u>		

DATE REC'D BY LOCAL REG. <u>11-19-55</u>	REGISTRAR'S SIGNATURE <u>Max Olan Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home - Sikeston Mo</u>	ADDRESS -----
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 21 1955

DATE RECEIVED _____

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1155 252

RECEIVED NOV 21 1955

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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 _____
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 346

P. O. Address Sekeston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.