

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 20 1956

24298

State File No. 5644

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BIRTH NO. _____		REG. DIST. NO. 174		PRIMARY REG. DIST. NO. 3035		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>				
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>Lexington township</b>		c. LENGTH OF STAY (in this place) <b>2 years</b>		c. CITY OR TOWN <b>Lexington</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Goodloe Rest Home</b>				e. STREET ADDRESS (If rural, give location) <b>221 South 5th St.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Cora</b> b. (Middle) <b>Belle</b> c. (Last) <b>Simpson</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 23 1956</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>April 30, 1876</b>		
9. AGE (In years last birthday) <b>80</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Wellington, Missouri</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James H. Crews</b>		13b. MOTHER'S MAIDEN NAME <b>Harriet Ann Töhler</b>		14. NAME OF HUSBAND OR WIFE <b>Comodore Simpson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mollie Martin</b> ADDRESS <b>Lexington, Mo.</b>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchial pneumonia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral thrombosis</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 year</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) <b>332X</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <b>March, 1951</b> , to <b>June 23, 1956</b> , that I last saw the deceased alive on <b>June 16, 1956</b> , and that death occurred at <b>1:00 p. m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>W. Koppenschnur, M.D.</b> (Degree or title)				23b. ADDRESS <b>Chiggmorelle Mo</b>		23c. DATE SIGNED <b>June 30-56</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>June 25, '56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Machpelah Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Lexington, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>7-12-56</b>		REGISTRAR'S SIGNATURE <b>Anna E. Sauter</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter R. Koppel</b> ADDRESS <b>Lexington, Mo.</b>				

(Licensed Embalmer's Statement on Reverse Side)

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

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JAN 29 1989

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.