

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009344
STATE FILE NUMBER

FILED MAR 17 1958

Registration District No. 82 Primary Registration District No. 5308 Registrar's No. 33

300
-57

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>					
b. CITY OR TOWN <u>Blackwater (Twp)</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Nelson 0278</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6 miles S of Nelson</u>			Length of stay in lb <u>40 years</u>		d. STREET ADDRESS (If outside, give location) <u>6 miles S of Nelson</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Cosby - OTHO - SIMPSON</u>				4. DATE OF DEATH <u>March 10, 1958</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 18, 1877</u>			
9. AGE (In years, if birthday) <u>80</u>		IF UNDER 1 YEAR <u>5</u> Months <u>22</u> Days		IF UNDER 24 HRS. <u>—</u> Hours <u>—</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (City and state or country) <u>Wayne County, Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13a. FATHER'S NAME <u>Cosby O. Simpson</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Odson</u>			14. NAME OF HUSBAND OR WIFE <u>Mary Laverie Simpson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year or unknown) (If yes, give year and dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mary Ruth Simpson Nelson, mo</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound Chest</u> DUE TO (b) <u>Self-inflicted</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>was</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Shot self with automatic 22 caliber rifle</u>					2	
20c. TIME OF INJURY Hour <u>8:30</u> a.m. Month <u>3</u> -Day <u>10</u> -Year <u>58</u>									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. CITY, TOWN, OR LOCATION <u>Cooper</u>		COUNTY <u>mo</u>		STATE	
21. I attended the deceased from <u>to attendance</u> and last saw her alive on <u>March 8, 1958</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>M. DeGraev</u> (Degree or title) <u>mo</u>				22b. ADDRESS <u>Carroll Booneville mo</u>				22c. DATE SIGNED <u>3/11/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Spec) <u>Burial March 12, 1958</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Salt Fork Ceme</u>		23d. LOCATION (City, town, or county) <u>Nelson, mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Hays - Painter, Pilot Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>3/11/58</u>		26. REGISTRAR'S SIGNATURE <u>D. Cooper</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

FEB 16 1959

VS FEB 25 1959

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 *Robert L. Paint*

Licensed Embalmer No. *4067*
P. O. Address *Pilot Grove*

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.