

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031868  
STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1034

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Doniphan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Troy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sisters Hospital		Length of stay in 1b 10 Days	d. STREET ADDRESS (If outside, give location) - - -		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last John Leslie Simpson			4. DATE OF DEATH Month Day Year Sept. 26 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/1870	9. AGE (In years) 87 (last birthday)	IF UNDER 1 YEAR Months Days 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 Agriculture	11. BIRTHPLACE (City and state or country) Paola Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME David Simpson		13b. MOTHER'S MAIDEN NAME Elizabeth Nelson		14. NAME OF HUSBAND OR WIFE Mary E. Simpson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Alden Simpson Address Troy Kansas		
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>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>4221</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>unknown</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>16 Sept 58</u> to <u>death</u> and last saw <u>him</u> alive on <u>26 Sept 58</u> Death occurred at <u>2:20 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Emerson Yoder M.D.</u>			22b. ADDRESS <u>Denton Kansas</u>		22c. DATE SIGNED <u>27 Sept 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/26/58	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City, town, or county) (State) Troy Kansas
24. FUNERAL DIRECTOR <u>Thomas B. Tibbets</u>		ADDRESS <u>Troy Kansas</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 29, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Hoodell</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Dr. Emerson Yoder

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 *Charles M. Harman* .....

Licensed Embalmer No. *4482* .....

P. O. Address *Waltham, Mass.*

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.