

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000349  
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 79

FILED JAN 26 1959

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. #2		d. STREET ADDRESS (If outside, give location) H. R. #3	
Length of stay in lb 1 yr. 8 months		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE SIMMONS			4. DATE OF DEATH Month Day Year Jan. 21, 1959		
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5. SEX female	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 August 31, 1880	9. AGE (In years last birthday) 78	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Fairport, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Oliver P. Barton	13b. MOTHER'S MAIDEN NAME Ellen Rininger	14. NAME OF HUSBAND OR WIFE Clarence H. Simmons
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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. unknown	17. INFORMANT Clarence H. Simmons, H. R. #3, St. Joseph, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterisclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 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 WORK <input type="checkbox"/> 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 St. Joseph	COUNTY Missouri	STATE
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21. I attended the deceased from Jan. 21, 1959 to Jan. 21, 1959 and last saw her alive on Jan. 21, 1959  
Death occurred at 11:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Mohammed Tahir M.D.	22b. ADDRESS State Hosp. #2, St. Joseph, Mo.	22c. DATE SIGNED 1/21/1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1/24/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph	(State) Missouri
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24. FUNERAL DIRECTOR Hester - Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Jan 22 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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Dr. Mohammed Tahir  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 ..... *Eugen Wood* .....

Licensed Embalmer No. *3804* .....

P. O. Address *319 1/2 10th St. H. G. W.* .....

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.