

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025801

STATE FILE NUMBER

Registration District No. 167 Primary Registration District No. 5609 Registrar's No. 31

FILED JUL 17 1961

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holder Route #2</u>		c. CITY OR TOWN <u>Holder</u>	
Length of stay in 1b <u>40 years</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>Residence</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Route #2</u>	
Midside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Winslow</u> Last <u>Simpson</u>			4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1961</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1881</u>	9. AGE (last birthday) <u>80</u>	
		9F UNDER 1 YEAR		IF UNDER 24 HR	
		Months		Days	
		Hours		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>General</u>	11. BIRTHPLACE (City and state or country) <u>Blairstown, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Richard Simpson</u>	13b. MOTHER'S MAIDEN NAME <u>Salena Wall</u>	14. NAME OF HUSBAND OR WIFE <u>Linnie Wall</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Linnie Simpson, Holder, Missouri</u>	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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>		
DUE TO (b) _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gen Arteriosclerosis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ p.m.	Month, Day, Year
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Jan 4 '55 to July 2, 1961 and last saw her 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Kelly Rawlins</u>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Holder MO</u>	22c. DATE SIGNED <u>7/4/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/5/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wall Cemetery</u>	23d. LOCATION (City, town, or county) <u>Holder, Missouri</u>
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24. FUNERAL DIRECTOR <u>Cook Funeral Home, Chilhowee, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-4-61</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Rose</u>
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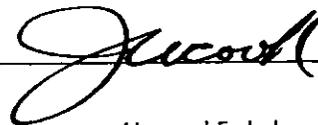
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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. 4335

P. O. Address Chelkover,

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.