

FILED FEB 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4005

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 5134		Registrar's No. 193	
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 OR TOWN Rural, Washington St., Joseph				c. CITY OR TOWN St., Joseph			
d. FULL NAME OF HOSPITAL OR INSTITUTION RR#1 Riverside Drive				d. STREET ADDRESS RR#1 Riverside Drive			
3. NAME OF DECEASED (Type or Print) a. (First) Chester		b. (Middle) E.		c. (Last) Simmon		4. DATE OF DEATH (Month) (Day) (Year) Feb. 16, 1950	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 12, 1881	
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Simmon		13b. MOTHER'S MAIDEN NAME Lydia Boyer		14. NAME OF HUSBAND OR WIFE Mattie E. Simmon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE AND NAME ADDRESS Mattie E. Simmon, R#1, St. Joseph, Mo.			
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) Hemorrhage Cerebral ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis General 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 7 day 15 yrs 3 3/4	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)			
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 5-14-97, 19__, to 2-16-50, 19__, that I last saw the deceased alive on 5-10-49, 19__, and that death occurred at 4:00P m., from the causes and on the date stated above.							
23a. SIGNATURE J. C. Boone M.D.				23b. ADDRESS 207 OVS Bldg St. Joseph, Mo.		23c. DATE SIGNED 2-17-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/18/1950		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Joseph Missouri	
DATE REC'D BY LOCAL REG. Feb. 23, 1950		REGISTRAR'S SIGNATURE G. B. Jenkins		382 FUNERAL DIRECTOR'S SIGNATURE Heaton-Brown		ADDRESS St. Joseph, Mo.	
(Licensed Embalmer's Statement on Reverse Side) None							

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

Dr. Olaner

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
Student Embalmer

Signed William Spelling

Licensed Embalmer No. 4535

P. O. Address 319 S. 10th St. St. Paul, Minn.

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 this body is not embalmed, fact should be so stated above.