

FILED SEP 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27943

BIRTH NO. 0930		REG. DIST. NO. 814		PRIMARY REG. DIST. NO. 4457		Registrar's No. 52	
1. PLACE OF DEATH a. COUNTY St. Clair				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Clair			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Osceola				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Osceola, Missouri. 0930			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) None.			
3. NAME OF DECEASED (Type or Print) Rosie		a. (First) Annie		c. (Last) SIMMONS		4. DATE OF DEATH (Month) (Day) (Year) Aug. 9 1950	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 4, 1867	9. AGE (In years last birthday) 82	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Christian Cripe		13b. MOTHER'S MAIDEN NAME Kathrine Replogle		14. NAME OF HUSBAND OR WIFE Thomas J. Simmons			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Chas. Simmons-Osceola, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH Hours 331X	
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) m.		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 1945 to Aug 9, 1950, that I last saw the deceased alive on Aug 7, 1950, and that death occurred at 2 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Ruth Seiers MD		23b. ADDRESS Osceola Mo		23c. DATE SIGNED Aug 10 50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 10, 1950		24c. NAME OF CEMETERY OR CREMATORY Pleasant Mound		24d. LOCATION (City, town, or county) (State) Rural-Osceola, Mo.	
DATE REC'D BY LOCAL REG. Aug 10-50		REGISTRAR'S SIGNATURE Ruth Seiers 288		25. FUNERAL DIRECTOR'S SIGNATURE Hutsler Funeral Home		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side) Osceola, Mo.

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

RECEIVED 9-5-50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 9-5-50

STATEMENT OF 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 _____

working under my personal supervision

Student Embalmer No. _____

Student _____
Student Embalmer

Signed

Charles H. Hutter Jr.

Licensed Embalmer No. 4629

P. O. Address Decatur, Mo.

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.