DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3126

Registration District No. 377 — Primary Registration District No. 5769 — Registrar's No. 1

1. PLACE OF DEATH:
(a) County Montcau
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community years, months or days) 150

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Montcau
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Susan Vinson
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Milton
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 30 (Day) 1846 (Year)

8. AGE: Years 93 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Montcau Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business
12. Name of FATHER Wm Hickam
13. Birthplace West Virginia (City, town, or county) (State or foreign country)
14. Maiden name of MOTHER Lydia Smith
15. Birthplace West Virginia (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Beulah Umbarger
(b) Address California, Mo.
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/12/40 (Month) (Day) (Year)
(c) Place: burial or cremation Masonic Cem
18. (a) Signature of funeral director Williams & Friedmeyer
(b) Address California Mo
19. (a) 1-13-40 (Date received local registrar) (b) H R Popejoy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan. day 10
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Jan. 1, 1940, to Jan. 10, 1940, that I last saw h[illegible] alive on Jan. 1, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Fracture of Hip -	Jan. 1

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. L. O'Banion (M. D. or other) DO
Address California, Mo Date signed 1/13/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

(Licensed Embalmer's Statement on Reverse Side)

1948

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_____

_____, Registered Apprentice No._____

working under my personal supervision.

Signed_____

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3121
Do not use this space.

1. PLACE OF DEATH
(a) County Moniteau Registration District No. 2-71
(b) Township Walnut Primary Registration District No. 3769 Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Susan Simon

(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	93	5	12	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 19 40 to only call 19
I last saw her alive on Jan 1 19 40 Death is said to have occurred on the date stated above, at 9 p m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Other contributory causes of importance: Fractured Hip Due to fall	Jan 1, 40

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) K. J. O'Bannon M. D.
(Address) California Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-3126