

## CERTIFICATE OF DEATH

File No. 23099

Registered No. \_\_\_\_\_

## 1. PLACE OF DEATH

County Musselman

Vet. Post. \_\_\_\_\_

Registration District No. 1090Inc. Town ReynoldsPrimary Registration District No. 2847

City \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME J. A. S. Simmons(a) Residence No. \_\_\_\_\_ St., \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. New long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. Single, Married, Widowed or Divorced (write the word) Widowed6a. If married, widowed, or divorced  
Name of  
(or) WIFE of \_\_\_\_\_

## 6. DATE OF BIRTH

7. AGE  
Years 80 Months 6 Days 13 If LESS than 1 day..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, sawmill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) 10/30 11. Total time (years) spent in this occupation 2512. BIRTHPLACE Pa.13. NAME Bill Simmons14. BIRTHPLACE Pa.15. MARRIAGE NAME Charles Suffer16. BIRTHPLACE Pa.17. INFORMANT Dr. J. H. Green(Address) Greenwood St. 1

18. BURIAL, CREMATION, OR REMOVAL

Place Samuel R. Co. Cemetery Date Sept. 7, 193019. UNDERTAKER H. R. H. H. H. H.(Address) Lawrence St. 1420. FILED Oct. 14, 1930 19. 25 Mrs. Craycraft

Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. 6<sup>th</sup>, 193022. I HEREBY CERTIFY, That I attended deceased from 10/21, 1930 to 10/30, 1930I last saw him alive on Sept 30, 1930, death is said to have occurred on the date stated above, at 10:30 a.m. The principal cause of death and related causes of importance in order of onset were as follows:Acute Nephritis  
and Chronic  
Cystitis  
10/21-27

Date of onset

Contributory causes of importance not related to principal cause:

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) LeRoy Miller, M. D.(Address) Beverly, Ky.

N. B. WRITE PLAINLY. UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PH should be stated EXACTLY. PH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.