S. F. No. 325—1921. Approved as to Form by Dept. of Efficiency. 4832.

PLACE OF DEATH

Washington State Board of Health

Record No. 3682

County of KING

BUREAU OF VITAL STATISTICS

Registered No. 3800

City or Town of SEATTLE

CERTIFICATE OF DEATH

Registration Dist. No. ____ No. 6727, Division N.W.

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

2. FULL NAME HENRY A. SIMONDS 553

(a) Residence No. 6727 Division N.W. St.;
(Usual place of abode)

(b) If non-resident, give city or town, and state ____

(c) How long in Registration Dist. 9 yrs. ____ mos. ____ ds.; how long in U. S. if of foreign birth ____ yrs. ____ mos. ____ ds.

Personal and Statistical Particulars

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (Write the word)
Male	White	Married

5. (a) If married, widowed or divorced:
Husband of Margaretta Simmonds
or
Wife of ____

6. Date of birth: April (Month) 9 (Day) 1861 (Year)

7. Age: 67 yrs. 8 mos. 7 ds. If less than one day: hrs. ____ or min. ____

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9. Birthplace (City or town): Athol
(State or country): Massachusetts

PARENTS

10. Name of Father: Albert Simonds
11. Birthplace of Father (City or town) (State or Country): Athol, Mass.
12. Maiden name of Mother: Sarah Woodstock
13. Birthplace of Mother (City or town) (State or Country): Athol, Mass.

14. Informant: Thomas Askren
Address: Lyon Bldg.

15. Filed Dec. 15, 1928 E. T. MANLEY, M. D. Registrar.

Medical Certificate of Death

16. Date of death: December (Month) 15 (Day), 192 8 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 192 8, to Dec. 15, 192 8, that I last saw him alive on Dec. 12, 192 8, and that death occurred on the date stated above, at 6 A. m.

(State the disease causing death, or in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL).

The CAUSE OF DEATH was as follows: 90

(Primary) Myocarditis

(Duration) ____ yrs. 2 mos. ____ ds.

CONTRIBUTORY (Secondary) Arthritis of back.

Hypertension, Influenza. (Duration) ____ yrs. ____ mos. 5 ds.

18. Where was disease contracted if not at the place of death? ____

(a) Did an operation precede death? No Date of ____

(b) Was there an autopsy? No

(c) What test confirmed diagnosis? Clinical only

(Signed) E. M. Carney M. D.

Dec. 15, 192 8 Address Med. & Dent. Bldg.

19. Place of Burial, Cremation or Removal: Cremation — Date of Burial: Dec. 16, 192 8

20. Undertaker: Bonney-Watson Co. — Address: Seattle, Wn.

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions ____ (Insert numbers of unanswered questions)

(Signature of Undertaker)

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