

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

Do not use this space.

38461

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... *St. Louis* (No. *906 N. 11th St.*)

File No.

Registered No. **11134**

St. Ward)

2. FULL NAME

(a) Residence. No. *906 N. 11th St.* St. *25* Ward.

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 15 1927*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *6 y 4 m 5 d*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Child*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Missouri*

10. NAME OF FATHER *Wm. Simmons*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Houston Texas*

12. MAIDEN NAME OF MOTHER *Lottie Simmons*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT (Address) *Wm. Dwyer Coroners Office*

15. FILED *11 13 1927* *Max B. Starckoff* REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-3-27* 19

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... *4:30 P*..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bacter. Enteritis
11 1/2 (duration)..... yrs..... mos..... da.
CONTRIBUTORY (SECONDARY) *Coronary*
11 30 (duration)..... yrs..... mos..... da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) *Wm. Dwyer* M.D.
12 13 1927 (Address) *Coroners Office*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Potters Field *12/13 1927*

20. URDERTAKER ADDRESS
Southern *7315 S. B. Hwy*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

