

Registration District No. **791** Primary Registration District No. _____

1. PLACE OF DEATH: **1008**
(a) County **St. Louis**
(b) City or town _____
(c) Name of hospital or institution: **St. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Weeks**
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME **Stanley B. Simpson**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W.**
6. (b) Name of husband or wife **Agnes** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 21 1862**
(Month) (Day) (Year)

8. AGE: Years **77** Months **2** Days **28** If less than one day _____ hr. _____ min.

9. Birthplace **Booneville Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Vice Prest.**

11. Industry or business **Meyer Bros. Drug Co. 4**

MOTHER FATHER { 12. Name **Simpson**
18. Birthplace **England**
14. Maiden name **Kate Brymen**
15. Birthplace **Penn.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Stanley B. Simpson**
(b) Address **7301 Melrose Ave.**

17. (a) **Calvary Church** (b) Date thereof **6-22-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **JUN 21 1939** (b) **J. P. Budek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. L. County**
(c) City or town **University City** (If outside city or town limits, write "RURAL")
(d) Street No. **1240 Weldon Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** 19 **19** day **19**
year **1939** hour **7** minute **55** p. M.

21. I hereby certify that I attended the deceased from **Dec. 28**
19 **36** to **June 19** 19 **39**;
that I last saw him alive on **June 19** 19 **39**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary edema - Duration 4 hrs.**
arterio-sclerosis-cerebral - yrs.
Hypertension
Due to **Generalized arterio-sclerosis**
Stenility

Egg to **Pul. Edema not pneumonia**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **no operation 97**
Of operations _____
Of autopsy **none done**

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?

While at work? _____ (Specify type of place)
(a) Means of injury _____

23. Signature **Howard A. Clark** (M. D. or other)
Address **3720 Washington** Date signed **6-24-39**

PHYSICIAN
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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 W H Van Mater

Licensed Embalmer No. 2825

P. O. Address 3840 Lundell

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, above space should be left blank.