

AUG 11 1939

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

24216

Do not use this space.

6489

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City, *St. Louis* (d) Street No. *Trisco Hospital* 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. mo. ds. (f) How long in U. S., if of foreign birth? yrs. 5 mo. ds.

2. PRINT FULL NAME

Charles R. Simpkins
(a) Residence, No. *Chaffee Mo* St. *WA* *Chaffee Mo*
(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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mrs. C. R. Simpkins*

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
ABOUT 52

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *machinist*
9. Industry or business in which work was done, as saw mill, bank, etc. *Trisco RR*
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation *16*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*13. NAME *Alfred Simpkins*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*15. MAIDEN NAME *Eizabeth Smith*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*17. INFORMANT (ADDRESS) *Patent Mrs. C. R. Simpkins
Chaffee Mo*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Chaffee Mo* DATE *7-24-1939*19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Rowland Mortuary, Inc.
4255 Washington*20. FILED *JUL 24 1939* *J. F. Budick
Local Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7/24/1939*22. I HEREBY CERTIFY, That I attended deceased from *7/24/1939* to *7/24/1939*I last saw him alive on *7/24/39*, 1939. Death is said to have occurred on the date stated above, at *7:04 a. m.*

The principal cause of death and related causes of importance were as follows:

Adverse Pt lung
106 ft

Date of onset

Other contributory causes of importance: *bronchectasis*Name of operation *none* 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? *No*

If so, specify

(Signed) *Hugh James J.*, M. D.(Address) *H. G. 60 Thistle*

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.

Signature *Howard P. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *St Louis, Mo*

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.