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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

LET AUG 11 1939

Registration District No.

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Wanda Simpson 5/2

3. (b) If veteran, name war _____ 3. (c) Social Security No. Nil

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 2, 1927
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 11 23 hr. min.

9. Birthplace Desloge Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School Child

11. Industry or business _____

12. Name James E. Simpson

13. Birthplace Steeltville Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Lillie Strickland

15. Birthplace Valley Mills Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James E. Simpson

(b) Address 8503 Riley Ave.,

17. (a) Burial (b) Date thereof 7/28/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Des Loge Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.,

19. (a) Jul 25 1939 (b) J. B. ...
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 8305 Riley RILEY AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1939 hour 7:02 minute A. M.

21. I hereby certify that I attended the deceased from 7/19/39
_____, 19____, to 7/25/39, 19____;
that I last saw her alive on 7/25, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial Endocarditis

Due to _____

Due to 9/a

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury? _____

23. Signature Harold Freedman (M. D. or other) _____

Address City Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 1 x19311

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.

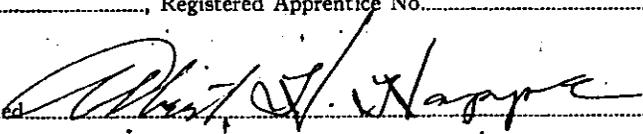
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No. 1861

P. O. Address.....

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.