S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 16 1947

Registration District No. 6076

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29981

Primary Registration District No. 6076

Registrar's No. 1674

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robt. Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 55 days (Specify whether years, months or days)
In this community: 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 0-06
(c) City or town: St. Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 1429a Clinton (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: SIMMONS, BEULAH IRENE
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Orla Simmons
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May (Month) 12 (Day) 1917 (Year)

8. AGE: Years 30 | Months 2 | Days 25 | If less than one day: hr. min.

9. Birthplace: (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: Eldon Hays
13. Birthplace: (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name: Elizabeth Moore
15. Birthplace: (City, town, or county) Illinois (State or foreign country)

16. (a) Informant: Hospital Records
(b) Address: Robert Koch Hospital
17. (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 8/10/47 (Month) (Day) (Year)
(c) Place: burial or cremation: CORNING, ARK.
18. (a) Signature of funeral director: Leidner Und. Co
(b) Address: 2223 St. Louis Ave
19. (a) 8-8-47 (Date received local registrar) (b) Carl A. Sherman M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: August day: 7 year: 1947 hour: 4 minute: 35 A. M.

21. I hereby certify that I attended the deceased from 6-13, 1947, to 8-7-, 1947; that I last saw her alive on 8-7-, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	6 yrs. (??)
Due to:	
Due to: 136	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause of which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury: 0

Signature: Bernard Friedman (M. D. or other) M.D.
Address: Koch Hospital Koch, Mo. Date signed: 8-7-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

SEP 18 1942

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.....Rex Campbell.....

Licensed Embalmer No.....3881.....

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, fact should be so stated above.