

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3236**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **2063** Registrar's No. **00079**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Clayton		c. CITY (If outside corporate limits, write RURAL and give township) Ferguson	
c. LENGTH OF STAY (In this place) 15 hrs		d. STREET ADDRESS (If rural, give location) 214 St. Louis Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) JULIA b. (Middle) c. (Last) SIMROE			4. DATE OF DEATH (Month) (Day) (Year) JAN. 7 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 20, 1887	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 3 Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laundry	11. BIRTHPLACE (State or foreign country) Ferguson, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Henry Simroe		13b. MOTHER'S MAIDEN NAME Eli,abeth Mester		14. NAME OF HUSBAND OR WIFE ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME William Simroe, Jennings, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 1 week

18. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anterior clerotic heart disease with decompensation			INTERVAL BETWEEN ONSET AND DEATH 490X Several years
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 490X			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from **JAN. 7, 1950**, to **JAN. 7, 1950**, that I last saw the deceased alive on **JAN. 7, 1950**, and that death occurred at **6:12 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Albert Lohie M.D.		23b. ADDRESS 601 S. Brentwood, Clayton, Mo.		23c. DATE SIGNED 1-8-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/10/50		24c. NAME OF CEMETERY OR CREMATORY Frieden Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo					

DATE REC'D BY LOCAL REG. 1-10-50		REGISTRAR'S SIGNATURE Herbert L. Lombardi		25. FUNERAL DIRECTOR'S SIGNATURE White Funeral Home	
				ADDRESS Ferguson, Mo.	

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *J. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Bergman, 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.