URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–034602
STATE FILE NUMBER

FILED VS SEP 28 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2521

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton
Length of stay in 1b: 6 DA.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Co. Hosp.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Glencoe
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Grand Ave
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Alveda Middle: Fay Last: Simpson
4. DATE OF DEATH: Month: Sept. Day: 21 Year: 1959
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/22/40
9. AGE (last birthday): 18
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): St. Louis Co., Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: James Simpson
13b. MOTHER'S MAIDEN NAME: Margaret McDaniel
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)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: James Simpson Address: Glencoe, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adrenal Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Adrenal Hypoplasia — Unknown
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Superficial Gastric Ulcer, Rheumatoid Arthritis.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 9-15-59 to 9-21-59 and last saw her alive on 9-21-59
Death occurred at 6:20 Am on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Ronald C. Passmore (Degree or title) M.D.
22b. ADDRESS: 601 S. Brentwood, Clayton, Mo
22c. DATE SIGNED:
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/23/59
23c. NAME OF CEMETERY OR CREMATORY: Bethel Cem.
23d. LOCATION (City, town, or county) (State): Fond, Mo.
24. FUNERAL DIRECTOR: Schrader, ADDRESS: Ballwin, Mo.
25. DATE RECD. BY LOCAL REG.: 9-22-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 _____
Signature of Student Embalmer

Signed Richard Bopp

Licensed Embalmer No. 458 d

P. O. Address Baldwin, Th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.