

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048125

FILED VS JAN 5 1961 317

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3733

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KIRKWOOD 22</b>		Length of stay in lb <b>1 WEEK</b>		c. CITY OR TOWN <b>GLENDALE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) <b>ST JOSEPH'S HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>213 CORNELIA AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JULIUS</b> Middle <b>JAMES</b> Last <b>SIMS</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>25</b> Year <b>1960</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-5-93</b>	9. AGE (last birthday) <b>67</b>	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) <b>SALESMAN RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NATL BISCUIT CO</b>		11. BIRTHPLACE (City and state or country) <b>CLINTON MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>THOMAS SIMS</b>			13b. MOTHER'S MAIDEN NAME <b>MATHILDA A BOUDINIER</b>			14. NAME OF HUSBAND OR WIFE <b>MARIE UMLAUF SIMS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>492-07-4914</b>		17. INFORMANT <b>Marie Umlauf</b> Address <b>213 Cornelia Ave</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease etc.</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>Dec 18 1960</b> to <b>Dec 25 1960</b> and last saw <sup>her</sup> him alive on <b>Dec 24 1960</b> Death occurred at <b>4:40 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>E. Deabaugh M.D.</b>				22b. ADDRESS <b>Webster Groves Mo.</b>				22c. DATE SIGNED <b>12/26/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-27-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		23d. LOCATION (City, town, or county) <b>KIRKWOOD 22 Mo</b>				
24. FUNERAL DIRECTOR <b>MITTELBERG</b>			ADDRESS <b>WEBSTER GROVES MO</b>		25. DATE RECD. BY LOCAL REG. <b>12-27-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.