

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-022232
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5884

FILED JUN 13 1963							
<p>1. PLACE OF DEATH</p> <p>a. COUNTY _____</p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in 1b <u>6 hours</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u></p> <p>c. CITY OR TOWN <u>Jennings</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>6340 Minnie Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>						
<p>3. NAME OF DECEASED First <u>Clara</u> Middle _____ Last <u>Simroe</u></p>							
<p>4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1963</u></p>							
<p>5. SEX <u>female</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>6-12-1888</u></p>	<p>9. AGE (last birthday) <u>74</u></p>	<p>IF UNDER 1 YEAR Months _____ Days _____</p>	<p>IF UNDER 24 HR Hours _____ Min. _____</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>George Tons</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>Christina Mittlehauser</u></p>			<p>14. NAME OF HUSBAND OR WIFE <u>deceased</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>				<p>17. INFORMANT Address <u>Mrs. C. W. Wilkinson, 8594 Forest Drive.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p style="text-align: center;">PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u></p> <p style="text-align: center;">DUE TO (b) _____</p> <p style="text-align: center;">DUE TO (c) <u>334x</u></p> <p style="text-align: center;">PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>						<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.</p>							
<p>22a. SIGNATURE (Degree or title) <u>Regina J. Quinn Deputy</u></p>				<p>22b. ADDRESS <u>1300 Clark</u></p>		<p>22c. DATE SIGNED <u>6-4-63</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>		<p>23b. DATE <u>6-4-63</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri.</u></p>	
<p>24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann and Son, Inc. 2161 E. Fair Ave.</u></p>				<p>25. DATE RECD. BY LOCAL REG. <u>JUN 4 1963</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u></p>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

58

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 Julius R. Brown

Licensed Embalmer No. 5146

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

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