26 2 [illegible]

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35679

1. PLACE OF DEATH

County ..... Registration District No. 781 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 10778

City St. Louis, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Gertrude Simpson

(a) Residence. No. 1905 Division St., M Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U.S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: color
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): unknown

7. AGE: 40 — Years: ✓ Months: ✓ Days: ✓ If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): /
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

PARENTS

10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

14. INFORMANT: Will Simpson
(Address) 1905 Division

15. FILED [illegible] 1928 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10-26-1928

17. I HEREBY CERTIFY, That I attended deceased from 10-24-1928, to 10-26-1928, that I last saw her alive on 10-26-1928, and that death occurred, on the date stated above, at 11 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92 Aortic Regurgitation

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY): Aortic Regurgitation

(duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED: unknown

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) L. E. Vincent, M. D.

, 19 (Address) 239a So. Jefferson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Father Dickson
DATE OF BURIAL: 11-3-1928

20. UNDERTAKER: B. Leonard Sund
ADDRESS: 3702 Lawton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.