

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

Do not use this space.

35692

1. PLACE OF DEATH

County.....
Township.....
City *St Louis*

Registration District No. **791**
Primary Registration District No. **1003**
(No. *St Lukes Hospital*)

File No.....
Registered No. **10484**
St. Ward)

2. FULL NAME

Paul Woodson Simpson
(a) Residence, No. *839 Balf Ave* St., *5* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *8* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Stella Coleen Simpson*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 7, 1885*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>44</i>	<i>7</i>	<i>16</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer) *Food p for plants*
(c) Name of employer *Floyd Plant food Co*

9. BIRTHPLACE (CITY OR TOWN) *Chain of Rocks*
(STATE OR COUNTRY) *Lincoln Co Mo*

10. NAME OF FATHER *John M. Simpson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Chain of Rocks*
(STATE OR COUNTRY) *Lincoln Co, Mo*

12. MAIDEN NAME OF MOTHER *Dora Woodson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Chain of Rocks*
(STATE OR COUNTRY) *Lincoln Co, Mo.*

14. INFORMANT *A. M. Simpson*
(Address) *839 Balf Ave*

15. FILED **OCT 25 1929** *W. C. Hardin* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **OCT 23 1929**

17. I HEREBY CERTIFY, That I attended deceased from *10 - 16 - 1929* to *10 - 23 - 1929* that I last saw h. m. alive on *10 - 13 - 1929*, and that death occurred, on the date stated above, at *6.25 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Malaria

CONTRIBUTORY (SECONDARY) *none*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. *Arkansas*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical & Lab.*

(Signed) *SA Edwards*

10/24/29 (Address) *4216 Shaw*

*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 *Troy, Mo* DATE OF BURIAL *Oct 26 1929*

20. UNDERTAKER *Alexander and Sons* ADDRESS *6175 Delman*

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.

Trust
4216 Street