

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

Do not use this space.

8914

1. PLACE OF DEATH

County Jackson Registration District No. 300
 Township McClellan Primary Registration District No. 100
 City St. Louis (No. Genl Hosp #2) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1706 Michigan St. 4 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 19, 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
49 9 3

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) Tennessee

10. NAME OF FATHER Robert Simmons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N. C.

12. MAIDEN NAME OF MOTHER Mollie (unk)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT Fleta Garner
 (Address) 1706 Michigan

15. FILED 3/24/30 M. M. Crone REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 22 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-10 _____, 1930 Mar 22, 1930 that I last saw him alive on Mar 31, 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) _____ yrs. _____ mos. _____ ds.

IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? St. M. Smith, M. D.
 (Signed) _____

3/27/30 (Address) Genl Hosp #2

*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 Ash Grove Mo DATE OF BURIAL 3/24/30

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lydia

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.

RECORD

