

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

791  
1003

Township.....

Primary Registration District No.....

City *St Louis*

(No. *2033 a, Market st*)

File No.....

17943

Registered No.....

5090

St..... Ward.....

**2. FULL NAME** *Jackson Simmons*

(a) Residence. No. *2033 a, Market St.* *21* 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 *Male* 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 *Agnes Simmons*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 11 1898*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
<i>32</i>		<i>2</i>	<i>7</i>	

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

9. BIRTHPLACE (CITY OR TOWN).....  
(STATE OR COUNTRY) *Ark*

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....  
(STATE OR COUNTRY) *do*

12. MAIDEN NAME OF MOTHER *do*

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

14. INFORMANT *Agnes her Simmons*  
(Address) *2033 a, Market st*

15. FILED *MAY 24 1930* *Wm C. Starke*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 18 1930*

17. I HEREBY CERTIFY, That I attended deceased from *5-13-1930*, to *5-18-1930*, that I last saw him alive on *5-18-1930*, and that death occurred, on the date stated above, at *6 p. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Acute myocardia*

*93A*

(duration) ..... yrs. .... mos. *6* ds.

CONTRIBUTORY *Acute myocardia*  
(SECONDARY)

(duration) ..... yrs. .... mos. *6* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *Unknown*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF .....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Symptoms*  
(Signed) *L. C. Vincent*, M. D.

. 19 (Address) *239 a So Jefferson*

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Washington Park Csm* DATE OF BURIAL *5-25 1930*

20. UNDERTAKER *E Seott 3015 Taylor ave* ADDRESS

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.

470  
7  
2  
38

