

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

Do not use this space.

DEC 20 1935

38178⁷

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Jeff Bks, Mo

Registration District No. 1123
Primary Registration District No. 6248 B
(No. Nazareth Convent)

File No. _____
Registered No. 403
St. _____ Ward _____

2. FULL NAME Sister M. Sophia Simond

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) Nazareth Convent

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 31, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 5 29 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housework

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Bazee, Savose
(STATE OR COUNTRY) France

13. NAME Balthiat Simond

14. BIRTHPLACE (CITY OR TOWN) France
(STATE OR COUNTRY)

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) France
(STATE OR COUNTRY)

17. INFORMANT Sister M. Jane
(ADDRESS) R. F. D. Jefferson Barracks

18. BURIAL, CREMATION, OR REMOVAL
PLACE Nazareth Cemetery DATE Dec. 5, 1935

19. UNDERTAKER G. Hoffmeister U. & L. Co.
(ADDRESS) 7814 S. Broadway

20. FILED Dec-2, 1935 A. Mourry
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 30, 1935

22. I HEREBY CERTIFY, That I attended deceased from Nov. 23rd, 1935, to _____, 19____

I last saw h. alive on Nov. 23rd, 1935. Death is said to have occurred on the date stated above, at 3.30 P. M.

The principal cause of death and related causes of importance were as follows:

Rubeola

Other contributory causes of importance: 46

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Paul Miller, M. D.
(Address) Jeff Bks 28 Mo

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.

OFFICE OF THE ATTORNEY GENERAL
STATE OF TEXAS
AUGUST 15, 1900

TO THE HONORABLE THE COMMISSIONERS OF THE GENERAL LAND OFFICE
AT DALLAS, TEXAS

SIR: I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above and in reply to inform you that the same has been referred to the proper authorities for their consideration.

Very respectfully,
J. W. WALKER,
Attorney General.

RECORDED
INDEXED

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County *St. Louis*
Township *Carondelet*
City (No.) St. Ward

Registration District No. *1173*
Primary Registration District No. *6248 B*

File No.
Registered No. *403* Ward

2. FULL NAME

Sister M. Sophia Simon

(a) Residence, No. St. 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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *M*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 5- 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED *Dec 2 1935 G. Mowery* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 30 1935*

22. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...

I last saw h. alive on ... 19... Death is said

to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

acute nephritis Date of onset

Other contributory causes of importance:

Intestinal cancer

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) *Samuel Wells*, M. D.

(Address) *Jefferson Bldg*

MISSOURI STATE BOARD OF HEALTH
SUPPLEMENTARY

5-38178

CONFIDENTIAL