

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

Do not use this space.

JAN 17 1938

44227

1. PLACE OF BIRTH

County Jackson
Township Greene
City St. Louis

Registration District No. 399
Primary Registration District No. 1002
(No. 2425 E. 9th)

File No. _____
Registered No. 5130
St. _____ Ward _____

2. FULL NAME

W. H. Simpson
(a) Residence, No. 2425 E. 9th St., _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Don't know

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. About 78

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 262 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) Don't know

MOTHER FATHER 13. NAME Don't know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT none (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Greene Lawn DATE 12-18-37

19. UNDERTAKER Carroll Deverson (ADDRESS) 3024 Forest

20. FILED Dec. 20, 1937 M. D. 11 Registrar. Onome

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 16, 1937

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

I last saw him _____ 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:

Chronic glomerular nephritis Date of onset 1309

Other contributory causes of importance: no

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

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

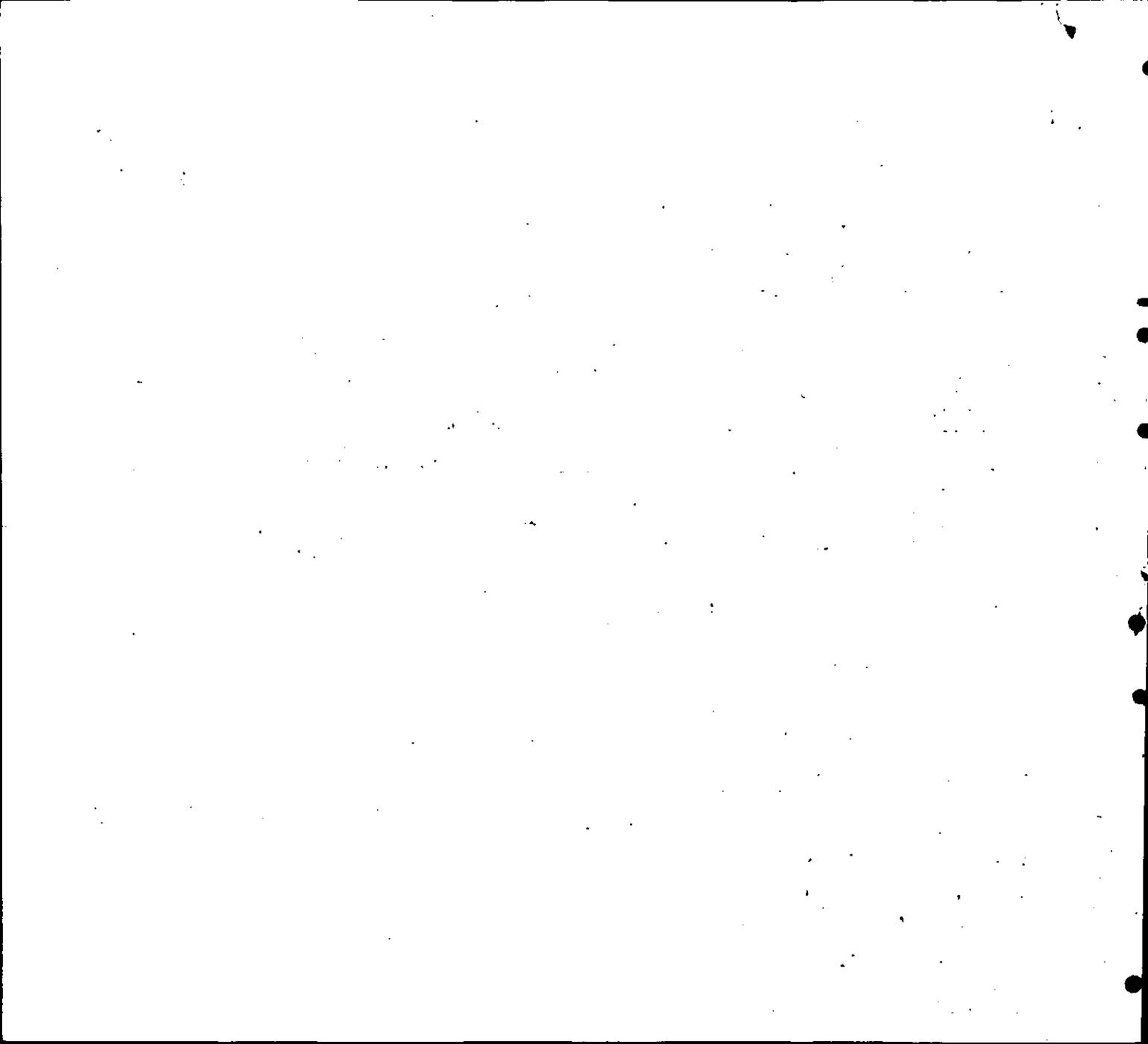
Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____ Nature of injury _____

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

(Signed) [Signature] M. D. _____ (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.



WRITE PLAINLY, WITH USUALLY INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

442274 Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Primary Registration District No. 1002 Registered No. 5730
(c) City X.C. (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

William H. Simpson
(a) Residence, No. (Usual place of abode, if no street address, write county or city) St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m/c

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. abt 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12-20-37 m m Crowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 16 1937

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:

Date of onset

Other contributory causes of importance:

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) C. I. Leitch, M. D.

(Address) X.C. m

SUPPLEMENTARY

