27 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40812

DEC 12 1939

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 2083

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.

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Normandy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1000 North Hills Dr. 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois 2 (b) County ____

(c) City or town Mt. Olive
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Frank Simmering 565

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Catherine | 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased July (Month) 22 (Day) 1860 (Year)

8. AGE: Years 79 | Months 4 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Germany 6 (State or foreign country)

10. Usual occupation Coal Miner 6

11. Industry or business ____

FATHER
12. Name Jacob Simmering 6
13. Birthplace ____ (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Gesine Suntken
15. Birthplace ____ (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Mrs. Louis Noser
(b) Address 1000 North Hills Dr.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/27/39 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) NOV 27 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-25 39
year ____ hour 11 minute P M.

21. I hereby certify that I attended the deceased from 10-21-39
____, 19__, to 11-25, 1939;
that I last saw him alive on 11-25, 1939;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	1 dy.
Due to Chr. Myocarditis	10 yrs
Due to Arteriosclerosis	10 yrs
Other conditions none (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature [signature] (M. D. or other)
Address 340 Bermuda Date signed 11-26-39

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....J. S. Sullivan.....

Licensed Embalmer No.....1122.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.