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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33168

BUREAU OF THE CENSUS
FILLED NOV 24 1941

Registration District No. 7-11

Primary Registration District No. 1003

Registrar's No. 8122

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-63
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution: EN ROUTE TO CITY HOSP. 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: 000

(a) State MO (b) County 12

(c) City or town ST. LOUIS 24 0
(If outside city or town limits, write "RURAL")

(d) Street No. 3361 S. 7th St.
(If rural, give location)

(e) Attending Physician
(If longer than, how long in U. S. A.? _____ years)

3. (a) PRINT FULL NAME NICHOLAS SIMON.

3. (b) If veteran, name war N

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11
year 1941 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: JULY 2 1878
(Month) (Day) (Year)

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Pushed chest, fractured ribs and sternum. Operated left hand. Fractured skull when he

8. AGE: Years 63 Months 3 Days 8
If less than one day hr. _____ min _____

walked into the side of a Broadway street car manned by Albert Ware son in front of about 3342 1/2 Broadway about 6:40 P.m. 10/10/41

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace: MAXVILLE MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation: BERR BOTTLES

11. Industry or business: UNEMPLOYED

Major findings: 712-6
Of operation _____

Of autopsy: 31 201

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name: HENRY SIMON.

13. Birthplace: FRANCES
(City, town, or county) (State or foreign country)

14. Maiden name: AURORA SCHOENHART

15. Birthplace: SWITZERLAND
(City, town, or county) (State or foreign country)

16. (a) Informant: Henry SIMON

(b) Address: R 8 Box 376 LEMAY

17. (a) BURIAL (b) Date thereof: 10/14/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Hope Cem.

18. (a) Signature of funeral director: J. B. Fisher

(b) Address: 912 S. Washington - Lemay

19. (a) OCT 12 1941 (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): Accident

(b) Date of occurrence: 10/10/41

(c) Where did injury occur? St. Louis MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place
(Specify type of place)

While at work? _____ (e) Means of injury: 3

23. Signature: Thomas J. Callahan (M. D. or other) _____
Address: Deputy Coroner Date signed: 10/11/41

FEB 11 1962

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80-1-1-2

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 *Harry J. Shumaker*

Licensed Embalmer No. *2679*

P. O. Address *332 Lemay*

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33.168
Registrar's No. _____

Registration District No. 791

Primary Registration District No. 1013

1. PLACE OF DEATH:

- (a) County St Louis
 - (b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
 - (c) Name of hospital or institution:
(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 _____ (b) County _____
- (c) City or town _____
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nicholas Simon

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 2 1872
(Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days _____ If less than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Buleck
(Registrar's signature) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 194 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I have seen him _____ live on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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? _____

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Enw 719

8/28

1941

1941
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