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S. No. 2
M-2-43
5-17-39
X35567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40562

FILED DEC 29 1943 318

1003

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 11398

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(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 97
(If outside city or town limits, write "RURAL")
(d) Street No. 3718a N. Euclid Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jane Hazel Simpson
3. (b) If veteran, name war No. 3. (c) Social Security No. None
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 19, 1885
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 18,
year 1943 hour 1:50 minute _____ P. M.
21. I hereby certify that I attended the deceased from December
15, 19 43 December 18, 19 43
that I last saw her alive on December 18, 19 43
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
58 1 29 hr. _____ min.

Immediate cause of death _____ Duration _____
Lobar Pneumonia
(Type III Pneumococci)
Due to _____
Due to _____
Other conditions _____ (Includes pregnancy within 3 months of death)
108

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

10. Usual occupation Domestic
11. Industry or business _____
12. Name ?
13. Birthplace Scotland _____
(City, town, or county) (State or foreign country)
14. Maiden name ?
15. Birthplace Scotland _____
(City, town, or county) (State or foreign country)

Major findings: _____ PHYSICIAN _____
Of operations _____
Of autopsy as above
Underline the cause to which death should be charged statistically.

16. (a) Informant Helen Braun
(b) Address 3718a N. Euclid Ave.

17. (a) Burial (b) Date thereof 12/21/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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?

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. at Concordia Lane
19. (a) DEC 20 1943 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature William J. Darr (M. D. or other) _____
Address 1515 Lafayette Ave. Date signed 12/20/43

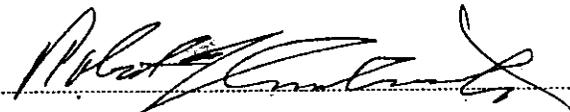
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

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

..... P. O. Address.....

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

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