

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5749**
Registrar's No. **1571**

Registration District No. **8448**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County Hagerman Phillips Hosp.
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Homer Phelps Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 month
 In this community 24 yrs
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME MOLLY SIMPSON
 3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race Col. 6. (a) Single, widowed, married, divorced, Widow
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased MARCH 19 1867
 (Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWORK

MOTHER FATHER

11. Industry or business _____
 12. Name UNKNOWN
 13. Birthplace UNKNOWN 9
 (City, town, or county) (State or foreign country)
 14. Maiden name UNKNOWN
 15. Birthplace DISBURG TENN
 (City, town, or county) (State or foreign country)

16. (a) Informant ROY SIMPSON
 (b) Address 1439 No. 9th St
 17. (a) BURIAL (b) Date thereof 2/17/44
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director M. J. Phelan
 (b) Address 2812 East Ave.
 19. (a) FEB 17 1944 (b) J. Z. Budech
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County 17
 (c) City or town St. Louis Mo 7
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1439 No 9th St 25
 (Rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 0

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb. day 11th
 year 1944 hour 8:25 minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of Rt. Hip Duration _____
Atherosclerosis suffered when
deceased slipped & fell to the
brick paved walk in the
yard in the rear of his home
at 1439 No. 9th St on or
about Jan 4 1944 exact time
 Due to _____
 Due to _____
 Other conditions Unknown
 (Include pregnancy within 8 months of death)

PHYSICIAN

Major findings: _____
 Of operations 186
 Of autopsy 27

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) 25 accident, suicide, or homicide (specify) _____ 000
 (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?

23. Signature Alfred Perry 3
 Address St. Louis (M.D. or other)
 Date signed 2/17/44

844

Embalmer separate cert. to be filed

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.