

FILED NOV 30 1944 318

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
 (a) County St Louis Mo.  
 (b) City or town St Louis Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Alexian Bros Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 Days  
 (Specify whether years, months or days)  
 In this community 32 Years in St Louis

3. (a) PRINT FULL NAME Frank Simokaitis

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 487-18-3350

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

6. (b) Name of husband or wife Constance Simokaitis 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Nov. 18 1894  
 (Month) (Day) (Year)

8. AGE: Years 50 Months 0 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Brewery Worker

11. Industry or business \_\_\_\_\_

12. Name Simon Simokaitis

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

14. Maiden name Unknown

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

16. (a) Informant Constance Simokaitis

(b) Address 3536 Humphrey St.

17. (a) Burial (b) Date thereof Nov 24, 44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Nov 23 1944  
Nov 23 1944 3758 Lafayette Ave.

19. (a) NOV 23 1944 (b) J. F. Brudeck  
 (Date of issue of local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3536 Humphrey  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21  
 year 1944 hour 1 00 A?M minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from Nov 19, 1944, to Nov 21, 1944  
 that I last saw him alive on Nov 20, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Neurophagia (Hemorrhagia of epistaxis)  
 Duration 2 days

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions Bronchial Pneumonia  
 (Include pregnancy within 3 months of death) Duration 5 days

Major findings: Of operations None

Of autopsy None

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) Means of injury \_\_\_\_\_

23. Signature W. Salisbury (M. D. \_\_\_\_\_)  
 Address 3758 Lafayette Date signed 11/22/44

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

**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 John Agonoski

Licensed Embalmer No. 3398

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.**