

Registration District No. **318** Primary Registration District No. _____

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:
8113 Pennsylvania Av.---
(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 **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **402 W. Davis**
(If rural, give location) **0 1**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CHARLES F. SIMON, Jr.**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **18**
year **1945** hour **3** minute **45 P.M.**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Nora Simon**
6. (c) Age of husband or wife if alive **51** years
7. Birth date of deceased **December 11, 1891**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **4/17** 1945, to **4/18** 1945;
that I last saw ~~him~~ **her** alive on **4/17/18** 1945;
and that death occurred on the date and hour stated above.

8. AGE: Years **53** Months **4** Days **7**
If less than one day _____ hr. _____ min.

Immediate cause of death **Coronary Arteriosclerosis 20 yrs**
Due to _____
Due to _____ **94**
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Switchman**
11. Industry or business **Manufacturers R. R.**
12. Name **Charles F. Simon, Sr.**
13. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Elia Keevins**
15. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nora Simon**
(b) Address **402 W. Davis St., St. Louis, Mo**
17. (a) **Burial** (b) Date thereof **4**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mount Hope Cemetery**
18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**
(b) Address **7814 S. Broadway, St. Louis, Mo.**
19. (a) **APR 19 1945** (Date received local registrar)
J. J. Bradach (Registrar's signature)

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 **0**
23. Signature **C. R. Hammer** (M. D. or other)
Address **7219 Michigan** Date signed **4/18/45**

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 *Lorine C. Hoffmeister*
Licensed Embalmer No. *3871*
P. O. Address *7814 S. Broad*

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.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution 8113 Pennway Home
(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 Charles F. Simon Jr
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month April day 18
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec-11-1891
(Month) (Day) (Year)

Immediate cause of death _____ Duration _____

8. AGE: Years 53 Months 4 Days 7 If less than one day _____ hr _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof 4/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address APR 27 1945

19. (a) APR 27 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

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? _____

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

SUPPLEMENTAL

11784