

SEP 1 1945 18

Registration District No.

Primary Registration District No.

1003

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: PARK LANE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME JERRY WAYNE SIMS

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced. 0

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

7. Birth date of deceased MARCH 3 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 21 hr. min.

9. Birthplace ST LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business 7

12. Name MELVIN SIMS

13. Birthplace STOUTSVILLE MO 0
(City, town, or county) (State or foreign country)

14. Maiden name IMOGENE SKONE

15. Birthplace DIXON MO 0
(City, town, or county) (State or foreign country)

16. (a) Informant MELVIN SIMS

(b) Address 1510 N. MARKET

17. (a) BURIAL (b) Date thereof 8-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STOUTSVILLE MO

18. (a) Signature of funeral director LEIDNER UND. CO

(b) Address 2223 ST LOUIS AVE

19. (a) AUG 25 1945 (b) J. F. Bricker
(Date of verbal report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 26 000
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1510 N. MARKET STR 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 24 th
year 1945 hour 5 minute A M.

21. I hereby certify that I attended the deceased from 8 - 23 1945 to 8 - 24 1945
that I last saw him alive on 8 - 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Edwards

Due to Dumb

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

(Specify type of place) _____

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

23. Signature J. F. Bricker (M. D. or other) _____

Address 4930 Lindbergh Date signed 8-24-45

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.....

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.