

S. No. 2
M-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
#11020
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15204
Registrar's No. 3901

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff Memorial
(d) Length of stay: In hospital or institution 40 days (Specify whether years, months or days) 40 years

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") 11/7
(d) Street No. 3225 Montgomery St. (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME August Simon
3. (b) If veteran, name war *** Nil
3. (c) Social Security No. *** Unknown
4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced, widower
6. (b) Name of husband or wife Unknown
7. Birth date of deceased February 14th, 1860 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 20th year 1946 hour 8:20 minute P M.
21. I hereby certify that I attended the deceased from 3/7/46 to 4/20/46 and that death occurred on the date and hour stated above.

8. AGE: Years 86; Months 2; Days 6
9. Birthplace Ohio (City, town, or county) (State or foreign country)
10. Usual occupation Unknown
11. Industry or business
12. Name Jacob Simon
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Dora Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Burial (b) Date thereof 4-29-46 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd
19. (a) 122 22 APR 29 1946 (Date received local health department) J. F. Brudack (Registrar's signature)

Immediate cause of death Pulmonary embolism
Due to Venous thrombosis 12-3 hrs
Due to 1/10
Other conditions R. mild high amputation (Include pregnancy within 3 months of death)

Major findings: Gangrene of foot
Of operations Not done
Of autopsy Not done
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. Renard 1515 Lafayette 4/20/46 (Date signed)

NO EMBALM

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.