

S. No. 2
M-5-43
5-17-39
X36371

FILED MAY 27 1946

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
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
929a W. Cabanne Ct.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution n one (Specify whether
 years, months or days) 49 yrs.

3. (a) PRINT FULL NAME Laura Simpson
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex female 5. Color or race col.
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Joseph Simpson
 6. (c) Age of husband or wife if alive deceased years
 7. Birth date of deceased Dec. 29 1896
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 3 27 hr. min.

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

10. Usual occupation nil

11. Industry or business nil

MOTHER FATHER

12. Name Manuel Gaines
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)

14. Maiden name (Grace) Stovall
 15. Birthplace Tolsa Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Katherine Simpson
 (b) Address 746 Aubert Ave.

17. (a) Burial (b) Date thereof 5. 1. 46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Allen Dailed
 (b) Address 3506 Franklin Ave.

19. (a) MAY 1 1946 J. F. Brebeck
 (Date received local registrar) (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. 929a W. Cabanne Ct. (If rural, give location)
 (e) Citizen of foreign country? (Yes) No
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26 year 46 hour 10 minute 10 A M.
 21. I hereby certify that I attended the deceased from 8 - 1946 to 4 - 26 1946
 that I last saw her alive on 4-26 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial Infarction
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 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 J. W. Welleson (M. D. or other)
 Address 3240 Traverce Ct. Date signed _____

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: *Sheldon J Mandell*

Licensed Embalmer No. *4243*

P. O. Address: *9277 Elm Dr
Webster, Mo*

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.