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DEPARTMENT OF HEALTH THE STATE BOARD OF HEALTH OF MISSOURI
 BUREAU OF VITAL STATISTICS
FILED JUN 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. **22210**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5076**

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:
St. Marys Infirmary
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 weeks**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Willette Simpson**
3. (b) If veteran, name war **No** **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 **6. (c) Age of husband or wife if alive** **years**

7. Birth date of deceased **March 18, 1867**
(Month) (Day) (Year)

8. AGE: Years **79** Months **2** Days **16** If less than one day **hr.** **min.**

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

10. Usual occupation **Nil**

11. Industry or business **Daniel Morman**

12. Name **Daniel Morman**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Leon Simpson**

(b) Address **3540 Lawton Ave**

17. (a) Burial **Calvary** **(b) Date thereof** **6-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **R. M. Green**
(b) Address **3517 Laclede Avenue**

19. (a) JUN 6 1946 **(b) J. F. Bredest**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **oau**
 (c) City or town **St. Louis** **1817**
(If outside city or town limits, write "RURAL")
 (d) Street No. **35 S. Channing Ave**
(If rural, give location)
 (e) Citizen of foreign country? **No**
(Yes or No) If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **4**
 year **1946** hour **1** minute **40** P.M.

21. I hereby certify that I attended the deceased from **Mar.**
15, 1946, to 6/4/46
 that I last saw h. **or** alive on **6/4/46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute myocarditis 3 MO. from Ch. Myo**
 Due to **9/3**

Due to **9/3**
 Other conditions **9/3**
(Include pregnancy within 3 months of death)

Major findings: **9/3**
 Of operations **9/3**
 Of autopsy **9/3**

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)
 (a) Means of injury **0**
23. Signature **Langhin C. Pugh** (M. D. or other)
Address **3464 Laclede** **Date signed** **6/5/46**

(Licensed Embalmer's Statement on Reverse Side)

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

21079

MOTHER FATHER

Duration **3 MO.**
 PHYSICIAN **9/3**
 Underline the cause to which death should be 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.....



Licensed Embalmer No. 1173

P. O. Address 3517 Soledad Ave

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.