

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U. S. GOVERNMENT PRINTING OFFICE: 1947
318
STANDARD CERTIFICATE OF DEATH

11549

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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:
4234a Hunt Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 5 years
years, months or days)

3. (a) PRINT FULL NAME SARAH JOSEPHINE SIMS

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

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced W 21
6. (b) Name of husband or wife John alive _____ years
7. Birth date of deceased September 2, 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 6 24 hr. min.

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

10. Usual occupation House-wife
At Home

11. Industry or business _____

12. Name John Evans

13. Birthplace ? No. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant William Sims

(b) Address Frisco Hospital

17. (a) burial (b) Date thereof 3-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) MAR 27 1947 (b) J. F. Bredes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4234a Hunt Avenue
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26th
year 1947 hour 3:15 minute _____ M.

21. I hereby certify that I attended the deceased from 3-1-1947 to 3-25-1947
that I last saw him alive on 3-24-1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic myocarditis

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 Oley J. Bone (M. D. or other) MD
Address 3616 S. Burdy Date signed 3-26-47

(Licensed Embalmer's Statement on Reverse Side)

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.....

H. B. Cooper

Licensed Embalmer No. *3633*

P. O. Address *2301 Lafayette*

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.