

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

15005

4016

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 25 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2931 a Olive Street			
3. NAME OF DECEASED (Type or Print) Robert		a. (First) Robert		b. (Middle) Sims		c. (Last) Sims	
4. DATE OF DEATH April 29 1950		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH January 4, 1899		9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		11. BIRTHPLACE (State or foreign country) Moscow, Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME Dont know		13b. MOTHER'S MAIDEN NAME Della Jackson		14. NAME OF HUSBAND OR WIFE Oneida Sims	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Oneida Sims, 2931a Olive Street			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Renal Insufficiency, Chronic, and Carcinoma of Prostate ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pericarditis				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 177X			
22. I hereby certify that I attended the deceased from 4-27 , 19 50 , to 4-29 , 19 50 , that I last saw the deceased alive on 4-29 , 19 50 , and that death occurred at 1:15 p m. , from the causes and on the date stated above.							
23a. SIGNATURE Ellis B. Bowers		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 5-1-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 5-4-1950		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St Louis, Missouri	
DATE REC'D BY LOCAL REG. MAY 3 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ELLIS FUNERAL HOME, INC., 2820 Stoddard St.			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

William E. Culkin

Signed.....

Student Embalmer

Licensed Embalmer No. *4198*

P. O. Address *St. Louis 13. 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.