.300
.48

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

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39055

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9743

1. PLACE OF DEATH

a. COUNTY: ~~5800 Arsenal St.~~

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST, Louis. MO.

c. LENGTH OF STAY (In this place): 4y, 7m, 9d.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): City Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE:

b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2139

d. STREET ADDRESS (If rural, give location): 5800 Arsenal St St. Louis Mo.

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) c. (Last) Simon

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1950

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): W

8. DATE OF BIRTH: Aug. 5, 1867

9. AGE (In years last birthday): 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): nil

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cottleville, St. Charles, Mo.

12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: John Simon

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS:

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1946 Plus

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Possible Prostatic Malignancy — 1949 Plus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

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) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 4200

22. *I hereby certify that I attended the deceased from* March 28, 19 46, *to* Nov. 1, 19 50, *that I last saw the deceased alive on* 11-1, 19 50, *and that death occurred at* 9,30P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Palmer Romaine Bowdish M.D. (Degree or title)

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify):

24b. DATE: NOV 17 1950

24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: NOV 17 1950

REGISTRAR'S SIGNATURE: J B Lasater

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rowland Mortuary Service Inc.

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.