

FILED FEB 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6655**
Registrar's No. **1163**

BIRTH NO. **45624-52** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 222 2829 Spruce St.	
3. NAME OF DECEASED (Type or Print) a. (First) Melvin b. (Middle) James c. (Last) Simpson		4. DATE OF DEATH (Month) (Day) (Year) Feb. 2 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH June 14, 1950
9. AGE (In years last birthday) 7 MONTHS 18 DAYS		9. AGE (In years last birthday) 7 MONTHS 18 DAYS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Spurgeon Simpson		13b. MOTHER'S MAIDEN NAME Maggie Sykes	
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) No	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Spurgeon Simpson, 2829 Spruce St.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Acute Diarrhea (Infectious)			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH Undet.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
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? 571.0		22. I hereby certify that I attended the deceased from 1-21 , 19 51 , to 2-3 , 19 51 , that I last saw the deceased alive on 2-3 , 19 51 , and that death occurred at 3:10a. m. , from the causes and on the date stated above.	
23a. SIGNATURE John Lewis		23b. ADDRESS 2601 N Whittier St.	
23c. DATE SIGNED 2-5-51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2-5-1951		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. B. Lasater Ellis Funeral Home, Inc. 2820 Stoddard St.	
DATE REC'D BY LOCAL REG. FEB 6 1951		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.	

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

12:1

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 _____

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Fulton E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address *St. Louis 13*

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.