

FILED JAN 10 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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1003 State File No. 11309

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		a. STATE Missouri b. COUNTY 2139	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		STREET ADDRESS (If rural, give location) 5829 Fyler Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) GEORGE	b. (Middle) J	c. (Last) SIMON	4. DATE OF DEATH (Month) (Day) (Year) DEC. 20, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 5, 1883	9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Erecting Signs	11. BIRTHPLACE (State or foreign country) New Cannan Conn.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Robert Simon	13b. MOTHER'S MAIDEN NAME Mary Jolley	14. NAME OF HUSBAND OR WIFE Johanna Simon
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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. 500-248-440	17. INFORMANT'S SIGNATURE OR NAME Mrs. Johanna Simon, 5829 Fyler Ave.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Leptomeningitis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
ANTECEDENT CAUSES		DUE TO (b) Hemophilus Influenzae bac.	
DUE TO (c)			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 3403
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22. I hereby certify that I attended the deceased from **12-17-51**, 19___, to **12-20-51**, 19___, that I last saw the deceased alive on **12-20-51**, 19___, and that death occurred at **9:04A** m., from the causes and on the date stated above.

23a. SIGNATURE Donald J. Smith M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 12-20-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial #1	24b. DATE 12-22-51	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. DEC 21 1951	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Cullinane Bros.	ADDRESS 3320 N. Kingshighway
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

See 0

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 Fred Trick

Signed.....
Student Embalmer

Licensed Embalmer No. 3186

P. O. Address St. Louis, 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.