

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3772**

FILED FEB 11 1953

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2229			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>22 2829 Chouteau</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jesse</u> b. (Middle) _____ c. (Last) <u>Simpson</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1953</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 8 1923</u>		9. AGE (In years last birthday) <u>29</u>	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) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>			
13a. FATHER'S NAME <u>Willey Simpson</u>			13b. MOTHER'S MAIDEN NAME <u>Annie B Primus</u>		14. NAME OF HUSBAND OR WIFE <u>Unice Simpson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>11</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm. Primus. 3134 Hickory</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
*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) <u>Tuberculous Meningitis</u>			Undet.		
				ANTECEDENT CAUSES			DUE TO (b) <u>Undetermined</u>		
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>None</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 <u>010X</u>					
22. I hereby certify that I attended the deceased from <u>1-19</u> , 19 <u>53</u> , to <u>1-23</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>53</u> , and that death occurred at <u>3:25 Pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Edward B. Williams M.D.</u>				23b. ADDRESS <u>2601 N Whittier St.</u>		23c. DATE SIGNED <u>1-26-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>Jan. 30, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barricks MO</u>				
DATE REC'D BY LOCAL REG. <u>JAN 27 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. J. Watson 2769 Chouteau</u>					

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

(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.....

Student Embalmer No. ....

.....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No. *2498*

P. O. Address *2769 Lakewood*

**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.