

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39490**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2471**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MO b. COUNTY St. Louis	
b. CITY OR TOWN Clayton		c. CITY OR TOWN Kimlock	
c. LENGTH OF STAY (in this place) 2 weeks		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION County Hospital		STREET ADDRESS (If rural, give location) 117 Jackson	

3. NAME OF DECEASED (Type or Print) Elizabeth			a. (First)		b. (Middle)		c. (Last) Simms		4. DATE OF DEATH (Month) (Day) (Year) 10 21 54				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct. 31-1870		9. AGE (In years last birthday) 84		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) None				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (City and State or Foreign Country) MO				12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Neal Spetzer		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Charles Simms	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Earl Simms ADDRESS 1045 Scott	

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) Pulmonary Embolus				5 min	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease					
		DUE TO (c) Hydrops of Gall Bladder					
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **10-8**, 19**54**, to **10-21**, 19**54**, that I last saw the deceased alive on **10-21**, 19**54**, and that death occurred at **2:05 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Cooper Kay M.D. (Degree or title)		23b. ADDRESS 601 So. Brentwood		23c. DATE SIGNED 10-21-54	
24a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		24b. DATE 10-25-54		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
		24d. LOCATION (City, town, or county) (State) 9500 Natural Bridge			

DATE REC'D BY LOCAL REG. 10/25/54		REGISTRAR'S SIGNATURE Harbert R. Smith		25. FUNERAL DIRECTOR'S SIGNATURE McClendon ADDRESS 4535 Washington	
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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

John R Cunningham

Licensed Embalmer No. 447

P. O. Address 2405 9th Ma

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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