

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3087

FILED JAN 29 1957

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **214**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis,</b> ) c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>St. Louis,</b> d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1523 Westminster</b>		e. STREET ADDRESS (If rural, give location) <b>4523 Westminster</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Philinia</b> b. (Middle) <b>Belle</b> c. (Last) <b>Simmons</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 7, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 29, 1857</b>
9. AGE (In years last birthday) <b>99</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Dent County, Missouri.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Wilson Cage</b>	
13b. MOTHER'S MAIDEN NAME <b>Martha Shuck</b>		14. NAME OF HUSBAND OR WIFE <b>John Simmons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No. Nil.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mary Simmons, 4523 Westminster</b>		ADDRESS	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerotic heart disease</i> <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 years.</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <b>420.0</b>	
20. AUTOPSY? <b>2</b> 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?			
22. I hereby certify that I attended the deceased from <b>July 2, 1945</b> , to <b>Jan 7, 1957</b> , that I last saw the deceased alive on <b>Jan 7, 1957</b> , and that death occurred at <b>4:30 A. M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Norton J. Eversoll M.D.</b>		23b. ADDRESS <b>6356 Clayton Rd. W. Union, Mo.</b>	
23c. DATE SIGNED <b>Jan 7, 1957</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-8-57</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Jadwin Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Jadwin, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 8 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>		ADDRESS <b>4700 Washington,</b>	

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..... *Robert M. Murray*

Licensed Embalmer No. *3749*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.