

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 26455

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6812

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN	
St. Louis		Missouri	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
16 Mo. Baptist Hosp.		31 601 Woodlawn	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last SIMON PHILLIP		Month Day Year JULY 21st, 1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 22, 1970
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)
Retired		Merchant	Mexico Missouri
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lewis Phillip		Cela Burk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Unk.	Sylvan Agatstein Ry. Exchange Bldg.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH
Myocardial Damage - Ischemia			2 yrs +
Crownary Type - General atherosclerosis			
Hypertension - Essential Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Left Ventricular Strain			2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
	420-1		
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from July 6/57 to July 21/57 and last saw him alive on July 20/57			
22a. SIGNATURE (Degree or title)			
J. N. Wellman, M.D.		22b. ADDRESS	
		8321 No. Broadway	
		22c. DATE SIGNED	
		7/22/57	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Cremation	7/22/57	Vallhalla Crematory	St. Louis County Missouri
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	
Herman Ridnskopf Inc. 5216 Delmar		III-2257	
		26. REGISTRAR'S SIGNATURE	
		J. Carl Smith, M.D.	
		M.D.B.	

OCT 17 1951

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 *Peter B. Dehouille*

Licensed Embalmer No. *369*

P. O. Address *Hay*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.