

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED SEP 4 1957

State File No. **30018**
Registrar's No. **7615**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 30018		Registrar's No. 7615						
I. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____										
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) 30 days		c. CITY OR TOWN St. Louis,		d. In 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 St. Louis Children's Hospital				e. STREET ADDRESS (If rural, give location) 970 4004 Westminster Place										
3. NAME OF DECEASED (Type or Print) John Allen Simmons			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 8-12-57		
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-30-57		9. AGE (In years last birthday) 4		10. IF UNDER 1 YEAR Days 12		11. IF UNDER 1 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) St. Louis			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME John Thomas Simmons				13b. MOTHER'S MAIDEN NAME Helen Jones				14. NAME OF HUSBAND OR WIFE None						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Dune Mansfield ADDRESS 500 S. Kings Highway								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH				
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration with Suffocation												
		ANTECEDENT CAUSES												
		*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.												
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.												
		DUE TO (b) Hydrocephalus												
		DUE TO (c) Congenital Displacement of Hypothalamus												
		II. OTHER SIGNIFICANT CONDITIONS												
		Conditions contributing to the death but not related to the disease or condition causing death.												
19a. DATE OF OPERATION August 10, 1957		19b. MAJOR FINDINGS OF OPERATION Craniotomy - Displacement of Hypothalamus								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) (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 7-13, 1957 to 8-12, 1957 that I last saw the deceased alive on 8-12, 1957 and that death occurred at 4:20 p.m. , from the causes and on the date stated above.														
23a. SIGNATURE D. J. Thuston (Degree or title) MD				23b. ADDRESS 500 S Kings Highway				23c. DATE SIGNED 8-12-57						
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 15, 1957		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.								
DATE REC'D BY LOCAL REG. AUG 14 57		REGISTRAR'S SIGNATURE J. Carl Smith MD				25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry ADDRESS 4202 Finney								

(Licensed Embalmer's Statement on Reverse Side)

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 *Leroy U. Barnister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Wash*

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.