Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003509

STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 403

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Missouri Pacific — Length of stay in 1b Hosp.10-days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN 2039 St.Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3820 Jamieson Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Charles Middle: A. Last: Simons

4. DATE OF DEATH Month: Jan. Day: 12 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 27,1897
9. AGE (In years last birthday): 61 — 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): Ill. Terminal R.R.
10b. KIND OF BUSINESS OR INDUSTRY: Employee
11. BIRTHPLACE (City and state or country): Bunker Hill, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: James Simons
13b. MOTHER'S MAIDEN NAME: Anna Sexton
14. NAME OF HUSBAND OR WIFE: Ellen M.Daily Simons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs.C.A.Simons Address: 3820 Jamieson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Brain Hemorrhage (Traumatic)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 983x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) suffered when bicycle by party or parties unknown about 912 pm., December 30th 1958, in the vicinity of 4557 Mary Avenue.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [X]
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY 912 Hour ~~a.m.~~ p.m. Month, Day, Year 12 30 58
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street
20f. CITY, TOWN, OR LOCATION St Louis COUNTY Mo STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 230 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dealer or title) Joseph M. Lillian Jr. Dealer
22b. ADDRESS 1200 Clark
22c. DATE SIGNED 1/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan.15,1959
23c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park
23d. LOCATION (City, town, or county): Edwardsville, (State) Illinois

24. FUNERAL DIRECTOR: WACKER-HELDERLE-3634 Gravois Ave. ADDRESS
25. DATE RECD. BY LOCAL REG.: JAN 13'59
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. M & J.B.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.