THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015726

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 3329

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2711 Stoddard — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Isabell — Middle: — Last: Simmons

4. DATE OF DEATH: Month 3 — Day 30 — Year 59

5. SEX: Female 3

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-30, 1898

9. AGE (In years last birthday): 60 YRS — 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): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Tallahasse, Miss.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Jim Brown

13b. MOTHER'S MAIDEN NAME: Annie M. Hill

14. NAME OF HUSBAND OR WIFE: Bennie Simmons

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.:

17. INFORMANT: Bennie Simmons — Address: 2711 Stoddard

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): A.S.H.D.

DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Nephrosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

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.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 2-18-59, to 3-30-59 and last saw her/him alive on 3-30-59

Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. G. Mace, M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 4-1-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 4-6-59

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem.

23d. LOCATION (City, town, or county): St. Louis City — (State): Mo

24. FUNERAL DIRECTOR: A.F. Walton — ADDRESS: 2707 Stoddard St.

25. DATE RECD. BY LOCAL REG.: APR 3 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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 embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student ..... Signed W. Claude Gordon .....

Signature of Student Embalmer

Licensed Embalmer No. 3489 .....

P. O. Address 4575 Aldine

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