

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023448
STATE FILE NUMBER
2 5599

FILED JUN 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. 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, give TOWNSHIP only) OR St. Louis TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR St. Louis TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5827 Enright Ave		Length of stay in lb 40 years	d. STREET ADDRESS (If outside, give location) 5827 Enright Ave
3. NAME OF DECEASED (Type or print) First HARRY JOHN Middle SYMONS Last		4. DATE OF DEATH Month June Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 5, 1883
10a. USUAL OCCUPATION (Give kind of work done during past 30 working days, even if retired) City water Dept.		10b. KIND OF BUSINESS OR RETIRED	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME John Symons		13b. MOTHER'S MAIDEN NAME Bessie Abbott	14. NAME OF HUSBAND OR WIFE Joanna Symons
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		17. INFORMANT Address Mrs. Joanna Symons, 5827 Enright Avenue.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) old Myocardial Infarction 5 yrs ago DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			INTERVAL BETWEEN ONSET AND DEATH acute
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.) 4201	
20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8/15/1953 to 6/10/1959 and last saw him alive on 6/2/1959 Death occurred at 6/10/59 9:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED 6/11/59	
22a. SIGNATURE (Degree or title) Thomas J. Fisher M.D.		22b. ADDRESS 4668	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 13, 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery
24. FUNERAL DIRECTOR Shepard Funeral Home, ADDRESS 1167 Hamilton Ave		25. DATE RECD. BY LOCAL REG. JUN 11 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Elton H. Remelius

Licensed Embalmer No. 4283

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.