

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. AUG 24 1959

59-030795

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

2 7242

STATE FILE NUMBER

DED

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 TOWN St. Louis, Missouri		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 805 Clinton Street			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wanda Middle Manda Last Simpson			4. DATE OF DEATH Month August Day 2 Year 1959						
5. SEX Female	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 12/23/86	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stripper			10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (City and state or country) Radom, Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Walenty Borowiak			13b. MOTHER'S MAIDEN NAME ? Sturman			14. NAME OF HUSBAND OR WIFE George Simpson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. _____		17. INFORMANT Address George Simpson, 805 Clinton Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Left Hip. DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) 904.0 21 Suffered in fall in Home							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 7 29 59 on or about July 29 1959.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo				
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at _____ 530 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Patrick Taylor Casner				22b. ADDRESS 1300 Clark			22c. DATE SIGNED 8.4.59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 6, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Missouri				
24. FUNERAL DIRECTOR JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.			25. DATE RECD. BY LOCAL REG. AUG 4 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. S.P.				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *E. W. Ruster*

Licensed Embalmer No. 3940

P. O. Address *H. L. Lewis*

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.