

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033737

FILED VS SEP 16 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 8095**

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b <b>Life</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		d. STREET ADDRESS (If outside, give location) <b>1825 No. 25th St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>GEORGE ALEXANDER DE-WITT</b> First Middle Last <i>also known as ALVIN A. SIMPKINS</i>			4. DATE OF DEATH Month <b>AUG.</b> Day <b>29,</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/1900</b>	9. AGE (last birthday) <b>59 years</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DIRECT MAIL ADV.CO.</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>OLIVER SIMPKINS</b>		13b. MOTHER'S MAIDEN NAME <b>JOHANNA KUNTZ</b>		14. NAME OF HUSBAND OR WIFE <b>ELSIE DE WITT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>495-16-0051</b>		17. INFORMANT <b>MRS. ELSIE DE WITT</b> Address <b>1829 No. 25 th</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho genic R lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>162.1</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <b>Epid Ca floor of mouth (h.)</b>		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 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.) <b>NO</b>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>8/20/59</b>	20f. CITY, TOWN, OR LOCATION <b>ST. LOUIS</b>	COUNTY <b>ST. LOUIS</b>	STATE <b>MISSOURI</b>
21. I attended the deceased from _____, to <b>AUG. 29, 1959</b> and last saw her/him alive on <b>AUG. 29, 1959</b> Death occurred at <b>10:10 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>James W. Handy M.D.</i>	(Degree or title) <b>M.D.</b>	22b. ADDRESS <b>1515 LAFAYETTE</b>	22c. DATE SIGNED <b>SEP 1 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>Sept 2, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ZION CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MISSOURI</b>
24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>SEP 1 1959</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4522

P. O. Address St Louis

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.