

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
FILED VS OCT 19 1959

59-038083

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9210**

MAILED

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		Length of stay in 1b 40 years	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3801 Gravois		d. STREET ADDRESS (If outside, give location) 3801 Gravois	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary of Saint Alphonsus (Mary Simpson)		4. DATE OF DEATH Month Day Year October 7th. 1959	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1879
9. AGE (last birthday) 80 years		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious of Good Sheperd	11. BIRTHPLACE (City and state or country) New Orleans La.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Samuel Simpson	13b. MOTHER'S MAIDEN NAME Jessie McDonald
14. NAME OF HUSBAND OR WIFE Never Married		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. no
17. INFORMANT Sr. Mary of St. Francis 3801 Gravois		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO (b) Adenocarcinoma of Sigmoid DUE TO (c) 153.3 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
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.)		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	
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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Dec 1958 to OCT 7, 1959 and last saw her alive on OCT 4, 1959 Death occurred at 9:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) John T Vandover MD	
22b. ADDRESS 1504 So Grand		22c. DATE SIGNED 10/7/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10-8-1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis Missouri
24. FUNERAL DIRECTOR Walter J. Donnelly 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. OCT 7 '59	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		26. REGISTRAR'S SIGNATURE mbS	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

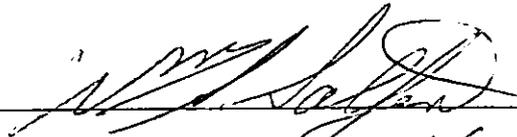
Dr. John Van Dover
1504 South Yarnall
3-6

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. 4699

P. O. Address 3840 Linder

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.