

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. FEB. 1 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **212037** - 59-047041 STATE FILE NUMBER

INDEXED

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|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                         |  | a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b> |  | c. CITY OR TOWN <b>St. John's</b>   |  |
| Length of stay in 1b  |  | d. STREET ADDRESS (If outside, give location)<br><b>8631 Belcrest Lane</b>            |  |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |  | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>               |  |

|   |                                  |   |   |   |  |  |
|---|----------------------------------|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>THERESA SIMONS</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Dec. 27 1959</b> |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-6-1880</b>                      | 9. AGE (last birthday)<br><b>79</b>                         | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stemmer-Liggett &amp; Myers Tobacco Co.</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Millstadt, Ill.</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>U.S.A.</b> |  |  |
| 13a. FATHER'S NAME<br><b>Abraham Simons</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Eva Kleam</b>   |   | 14. NAME OF HUSBAND OR WIFE<br>-----                        |  |  |

|   |  |   |                                     |
|---|--|---|-------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>489-10-5567a</b> | 17. INFORMANT<br><b>Evelyn Foerstel</b> | Address<br><b>8631 Belcrest La.</b> |
|---|--|---|-------------------------------------|

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|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Fractured Left Hip</b>   |  |  |
| DUE TO (b) <b>Arteriosclerosis</b>  |  |  |
| DUE TO (c) _____  |  | <b>902.7 45</b>  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|---|--|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>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.)<br><b>Slipped in fall from bed at St. Louis Chronic Hospital on or about 9 December 1959.</b> |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br><b>11:23 p.m.</b>  | 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.)<br><b>Hosp</b>  | 20f. CITY, TOWN, OR LOCATION - COUNTY STATE<br><b>St. Louis Mo</b> |

21. I attended the deceased from **131** to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                   |  |
|--|-----------------------------------|--|
| 22a. SIGNATURE (Degree & Title)<br><b>Carl Smith M.D.</b>                | 22b. ADDRESS<br><b>1300 Clark</b> | 22c. DATE SIGNED<br><b>12/28/59</b>                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>              | 23b. DATE<br><b>Dec. 29, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b> |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Kriegshauser 4228 S. Kingshighway</b> |                                   | 23d. LOCATION (City, town, or county)<br><b>St. Louis Co. Mo.</b>  |

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| 25. DATE RECD. BY LOCAL REG.<br><b>DEC 28 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith, M.D.</b> |
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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 Edwin A. McArthur

Licensed Embalmer No. 3024

P. O. Address \_\_\_\_\_

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.