

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007782

FILED VS FEB 16 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 27

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St Charles</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Charles</u>		Length of stay in 1b <u>40 yrs</u>		c. CITY OR TOWN <u>St Charles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>206 So. Main St</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>206 So. Main</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED First Middle Last <u>Jacob N Simonds</u>				4. DATE OF DEATH Month Day Year <u>Jan 29 1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21 1883</u>	9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (City and state or country) <u>Otterville Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>W.F? Simonds</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Potter</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-07-5873</u>		17. INFORMANT Address <u>Miss Billie Peabody St Charles Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure Arrest</u>							INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Medullary Failure</u>							<u>minutes</u>	
DUE TO (c) <u>Cerebral Vascular Accident</u>							<u>3 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
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 <u>Oct 20 - 1959</u> to <u>Jan 29 - 1960</u> and last saw ^{her} him alive on <u>Jan 29 - 1960</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>J. R. Harrington D.O.</u>				22b. ADDRESS <u>230A. no. main St. Charles Mo</u>			22c. DATE SIGNED <u>Jan 31 '60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/1/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town, or county) <u>St Charles Mo</u>			(State)
24. FUNERAL DIRECTOR ADDRESS <u>Arthur C Baue St Charles Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Feb. 1 - 60</u>		26. REGISTRAR'S SIGNATURE <u>Marella Wilson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EXAR

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 David P. Bane

Licensed Embalmer No. 5060

P. O. Address St. Charles

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.