RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

[redacted]

FILED VS MAR 7 1960 — Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1984 — STATE FILE NUMBER 60-008888

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 4 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5387 Wells — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: — Last: Simpson
4. DATE OF DEATH: Month 2 — Day 17 — Year 60
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/5/1888
9. AGE (last birthday): 71 — IF UNDER 1 YEAR: Months 6, Days 12 — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (City and state or country): St. Joseph, La.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Will Simpson
13b. MOTHER'S MAIDEN NAME: Louisiana Malone
14. NAME OF HUSBAND OR WIFE: -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 412-07-9713
17. INFORMANT: Mosella Lane — Address: 1460 Arlington Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 491x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cerebral Arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 2-10-60, to 2-17-60 and last saw him alive on 2-17-60
Death occurred at 12:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sydney A. Imes (Degree or title)
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 2-19-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Feb. 20, 1960
23c. NAME OF CEMETERY OR CREMATORY: FATHER DICKSON
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR: Jas. H. Randle and Son — ADDRESS: 3133 Bell Ave.
25. DATE RECD. BY LOCAL REG.: FEB 19 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. S.O.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF — DOCUMENT

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 Not Embalmed, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jas H. Randle

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.