

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. AUG 16 1960

60-033421

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2208 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <del>St. Louis</del>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch</b>		Length of stay in 1b <b>26 days</b>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rob't. Koch Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4659 Page</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>R.</b> Last <b>Simmerock</b>			4. DATE OF DEATH Month <b>7-</b> Day <b>21-</b> Year <b>60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-8-32</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newstead &amp; Town Curtain</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaners-Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>Lawrence, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Simmerock</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Krebs</b>		14. NAME OF HUSBAND OR WIFE <b>late Mary A. Simmerock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>496-36-5069</b>		17. INFORMANT Address <b>Robt. Koch Hospital Record Room, Koch, Mo.</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>Coronal infarct (ext. hemiplegic.)</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>Myelonephritis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>6-25-60</b> to <b>7-21-60</b> and last saw her/him alive on <b>7-21-60</b> Death occurred at <b>11:35</b> <b>A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Bernard Truman, M.D.</b>			22b. ADDRESS <b>Robt. Koch Hospital, Koch, Mo.</b>		22c. DATE SIGNED <b>7-21-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway</b>		25. DATE RECD. BY LOCAL REG. <b>7-23-60</b>	26. REGISTRAR'S SIGNATURE <b>John B. Mumford, M.D.</b>		

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

for by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed William B. White

Licensed Embalmer No. 4291

P. O. Address 4228 Kings

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.