

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

VS JAN 16 1961

318

1003

248 - 61-003671

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b		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>Homer G, Phillips</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1015 N. 20th St.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Webster Buck Simpson</b>			4. DATE OF DEATH Month Day Year <b>1 6 61</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4 1890 70</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>		11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>		
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13a. FATHER'S NAME <b>Samuel Simpson</b>		13b. MOTHER'S MAIDEN NAME <b>Hattie</b>		14. NAME OF HUSBAND OR WIFE <b>Sadie Simpson</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Sadie Simpson 1015 20th st. Sadie Simpson</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>Acute Monocytic Leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>204.2</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. <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 <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 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 <b>1-3-61</b> , to <b>1-6-61</b> and last saw <sup>her</sup> him alive on <b>1-6-61</b> Death occurred at <b>11:10</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Andrew D. Drake, M. D.</b>				22b. ADDRESS <b>2601 N. Whittier St.</b>			22c. DATE SIGNED <b>1-9-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/ 12 / 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION (City, town, or county) <b>Wallerston, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Reliable Funeral Sys. 1389 Union</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 9 1961</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

**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 Clarence Croam

Licensed Embalmer No. 4755  
P. O. Address 1387 Union

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.