

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035466

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2518

STATE FILE NUMBER

AMENDED

FILED SEP 19 1961

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rock Hill | | Length of stay in 1b 5 Weeks | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Rock Hill Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3450 Halliday Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|-------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Nancy Simpson | | | 4. DATE OF DEATH Month Day Year Sept. 5 1961 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/26/1879 | 9. AGE (last birthday) 82 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife retired | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Eldorado, Illinois | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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|---|--|---|---|---|--|--|
| 13a. FATHER'S NAME James Gaylord | | 13b. MOTHER'S MAIDEN NAME Banks | | 14. NAME OF HUSBAND OR WIFE Charles | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) nil | | 16. SOCIAL SECURITY NO. nil | 17. INFORMANT Address Mrs. M. S. Hall 3450 Halliday 18, Mo. ST. Louis | | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) | DUE TO (b) 420.0 | |
| DUE TO (c) | | |

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| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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 | | |

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|--|--|------------------------------|--------|-------|
| 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 August 1, 1961 to Sept. 5, 1961 and last saw her her alive on Sept. 4, 1961
Death occurred at 3:15 A on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>Robert Sanders, M.D.</i> (Degree or title) | 22b. ADDRESS 1402 Cass St. St. Louis | 22c. DATE SIGNED 9-6-61 |
|---|--|-----------------------------------|

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|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 9/7/1961 | 23c. NAME OF CEMETERY OR CREMATORY Old Popular Bluff City Cem. Sect. | 23d. LOCATION (City, town, or county) (State) Popular Bluff, Missouri |
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| 24. FUNERAL DIRECTOR JAY B. SMITH ADDRESS Maplewood Mo. | 25. DATE RECD. BY LOCAL REG. 9-6-61 | 26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i> |
|---|---|---|

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 H. J. Burgess

Licensed Embalmer No. 4029
P. O. Address Maplewood

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.