

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-046867

STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12318**

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 <b>26 yrs</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" 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>2863 Semple</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Grady</b> Middle <b>Simpson</b> Last <b>Simpson</b>	4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>61</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-1922</b>	9. AGE (last birthday) <b>39</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>25</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hope Ark</b>	11. BIRTHPLACE (City and state or country) <b>U S A</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Henry Simpson</b>	13b. MOTHER'S MAIDEN NAME <b>Ida Phillips</b>	14. NAME OF HUSBAND OR WIFE <b>Candies Simpson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	17. INFORMANT Address <b>Ida Simpson 2863 Semple Ave</b>
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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) <b>Carcinoma of Tonsils with Metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>145.0</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 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.)
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20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>	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 <b>St. Louis</b> COUNTY <b>Co</b> STATE <b>Mo</b>
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21. I attended the deceased from <b>12-24-61</b> to <b>12-28-61</b> and last saw him alive on <b>12-28-61</b> Death occurred at <b>9:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>J. O. Richards MD</i> (Degree or title)	22b. ADDRESS <b>2601 N. Whittier Street</b>	22c. DATE SIGNED <b>12-28-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co Mo</b>
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24. FUNERAL DIRECTOR <b>JAS H. RANDLE &amp; SON</b> ADDRESS <b>3133 Bell Ave</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 30 1961</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>
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DATE AMENDED

INSTEAD OF 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Wash

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.