SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11958

-61-046869
STATE FILE NUMBER

AMENDED

FILED JAN 5 1962

DATE AMENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MO. BAPTIST HOSP.
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO.
b. COUNTY

c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes [X] No [ ]

d. STREET ADDRESS (If outside, give location): 2202 NO. 10th. ST.
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First LENA Middle Last SIMS

4. DATE OF DEATH: Month DEC. Day 20 Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH: 10-20-77

9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (City and state or country): UNKNOWN ARK.

12. CITIZEN OF WHAT COUNTRY: U S A

13a. FATHER'S NAME: UNKNOWN

13b. MOTHER'S MAIDEN NAME: UNKNOWN

14. NAME OF HUSBAND OR WIFE: SAMUEL SIMS

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.: #

17. INFORMANT Address: MRS PAT DOYLE 3330 BLAIR 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 + virus infection — INTERVAL BETWEEN ONSET AND DEATH: 5 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Chronic bacterial bronchitis — years

DUE TO (c): 50.2.1 F

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I(a): Old fracture R. hip with deformity

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

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 12/19/60 to 12/20/61 and last saw him alive on 12/17/61

Death occurred at 12 noon p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title): Thomas Allen MD

22b. ADDRESS: 3720 Washington Ave

22c. DATE SIGNED: 12/21/61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 12-22-1961

23c. NAME OF CEMETERY OR CREMATORY: MEMORIAL PARK CEM.

23d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY, MO

24. FUNERAL DIRECTOR ADDRESS: STROOT CARROLL 4600 NATURAL BRIDGE

25. DATE RECD. BY LOCAL REG.: DEC 21 1961

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

ITEM NO. SHOULD READ INSTEAD OF BY AFFIDAVIT OF DOCUMENT

Dr Alex
JE 36525
3720 WASHINGTON

CITY HOSP.
HOME CARE.

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 M W Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis 9

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.