

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

23107

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. 815 Chouteau Ave.)

File No.....
 Registered No. 6800
 St. Ward)

2. FULL NAME

Rose Evans
 (a) Residence. No. 815 Chouteau St., 22 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unknown</u>		
7. AGE <u>abt 34</u>	YEARS <u>✓</u>	MONTHS <u>✓</u>
	DAYS <u>✓</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Factory Worker</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

PARENTS	10. NAME OF FATHER	<u>-</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN). (STATE OR COUNTRY)	<u>-</u>
	12. MAIDEN NAME OF MOTHER	<u>-</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN). (STATE OR COUNTRY)	<u>-</u>

14. INFORMANT Wm Dever
 (Address) Coroner Office

15. FILED 11 27 1927 Max G Starneff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-24-27
 17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Body badly decomposed
Cause of Death not ascertainable

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 205 1st
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY..... W. M. A.

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) Wm Dever M.D.
7/27/27 (Address) Dep Coroner

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL 7/27 1927

20. UNDERTAKER Southern N. L. Co ADDRESS 7315 S. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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