

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

Do not use this space.

7350

1. PLACE OF DEATH

County..... Registration District No. **79I**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. City Hospital #2)

File No.....
 Registered No. **2453**
 St. 11th Ward

2. FULL NAME

Baby Evans
 (a) Residence. No. 140 1/2 N. 11th St., 25 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 6, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Nil
 (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) St. Louis, Mo.

10. NAME OF FATHER Grace Evans

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) Ala.

12. MAIDEN NAME OF MOTHER Mattie Agnew

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) Ala.

14. INFORMANT (Address) Umma F. Woodard, City Hospital #2

15. FILED 11-23-28 Maule Starover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12, 1928
 17. _____

I HEREBY CERTIFY That I attended deceased from Feb. 6, 1928 to Feb. 12, 1928 that I last saw her alive on Feb. 12, 1928, and that death occurred, on the date stated above, at 5:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
159
161A (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: not

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) L. B. Thomas, M. D.
 , 19 (Address) City Hosp #2

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
11th St. Burial 3-6-1928

20. UNDERTAKER ADDRESS
R. Aston 2945 Lawton

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.

