

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

Do not use this space.

4666

1. PLACE OF DEATH

County..... Registration District No. 781
 Township..... Primary Registration District No. 11003
 City St. Louis (No. En Route to City 2 Lap #1)
 Registered No. 1552 St. _____ Ward _____

2. FULL NAME

Charles Evans
 (a) Residence. No. unknown St. 23 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>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>unknown</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unknown</u>		
7. AGE <u>abt 50</u>	YEARS <u>✓</u>	MONTHS <u>✓</u>
	DAY <u>✓</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>unknown</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) <u>unknown</u>		
10. NAME OF FATHER _____		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		
12. MAIDEN NAME OF MOTHER _____		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-20 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, m.

THE CAUSE OF DEATH, WAS AS FOLLOWS:
Multiple Slab Wounds of Chest and Body
174 Knife
 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS?
1/29 1929 (Signed) Wm V. Dever M.D.
 (Address) Corners Office

*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 Galliers Field DATE OF BURIAL 1/29 1929
 ADDRESS 7315 S Broadway

20. UNDERTAKER Southern

14. INFORMANT Wm V. Dever
 (Address) Corners Office

15. FILED 28 May 2 1929
 REGISTRAR

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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