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

Do not use this space.

29290

1. PLACE OF DEATH

County St Louis Registration District No. 1822 File No.

Township Primary Registration District No. 3[illegible] Registered No. 8427

City St Louis (No. St Louis Childrens Hospital St. Ward)

2. FULL NAME Evelyn Hamers

(a) Residence. No. 8501 Pennsylvania Av St. 1 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17, 1922

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER William Hamers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Dorothy Bauer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

14. INFORMANT Dorothy Hamers
(Address) 8501 Pennsylvania

15. FILED ..., 19... Max C. Tarkery
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18th 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at 4:00 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tetanus
Due to Stepping on Glass Accident (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (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? No
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Lemen, M. D.
8/19, 1929 (Address) Dep. Coro

*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	DATE OF BURIAL
Park Lawn	8/21 1929
20. UNDERTAKER	**ADDRESS**
E. Hofmeister U & L Co	7815 Gravois Blvd

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.