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

38128

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11284

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

2. FULL NAME Evan George

(a) Residence. No. 1537a Jefferson St. 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 30 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)
Male	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 24 — 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	76	9	6.	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

PARENTS
10. NAME OF FATHER Evan George Sr
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) England
12. MAIDEN NAME OF MOTHER Mary Fowler
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Alabama

14. INFORMANT Informant Rowan
(Address) City Hospital

15. FILED DEC -1 1930 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 30 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1930 to Nov 30, 1930 that I last saw him alive on Nov 30, 1930, and that death occurred, on the date stated above, at 8:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93C
97
97B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Gangrene left leg
arteriosclerotic non diabetic (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Joseph T. Maher, M. D.
12/1, 1930 (Address) City Hospital

*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
St Mathews	12-1 1930
20. UNDERTAKER	ADDRESS
McLaughlin	1631 Mo Av

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....Ward)

2. FULL NAME.....

(a) Residence. No.....St., ...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)

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

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

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT.....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
..... (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? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

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.