

No. 2  
8-43  
17-39  
X37823

FILED MAY 25 1944

Registration District No. 318

Primary Registration District No. 1008

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 days  
(Specify whether  
In this community 19 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1233 N. Garrison  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Madeline Evans

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

4. Sex P  
5. Color or race Col.

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife Hubert E. Evans  
6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased: June 13 1916  
(Month) (Day) (Year)

8. AGE: Years 27 Months II Days I  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Hopkinsville Ky.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name Jack Shouse  
13. Birthplace Hopkinsville Ky.  
(City, town, or county) (State or foreign country)  
14. Maiden name Minnie Shelton  
15. Birthplace Hopkinsville Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie Shouse  
(b) Address 1233 N. Garrison  
17. (a) Burial (b) Date thereof May 20, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Wright's Funeral Home.  
(b) Address 3100 Easton Ave.

19. (a) MAY 18 1944 (b) J. J. Brueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14,  
year 1944 hour \_\_\_\_\_ minute 35 A.M.

21. I hereby certify that I attended the deceased from April 29,  
1944, 19 \_\_\_\_\_, to May 14, 19 44  
that I last saw her alive on May 14, 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death: Thyrototoxicosis  
Duration Unk.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Alva Moore (M. D. \_\_\_\_\_)  
Address Shawwhetter Date signed 5/14/44

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *H. Claude Gordon*.....  
Licensed Embalmer No. *3489*.....  
P. O. Address..... *4575 Aldine*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Madeline Evans

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hubert 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased June 13 1916  
(Month) (Day) (Year)

8. AGE: Years 27 Months 11 Days 1 (Unless than one day) min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name.....  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) JUN 2 1944 (b) J. F. Medaek  
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 14 year 1944 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from 11 to 11 1944; that I last saw him alive on 13 1944 and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....  
Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

10320