

FILED MAY 25 1944 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

4414

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town _____
(c) Name of hospital or institution H. Phillips Hosp. 0
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Robert Allen Evers

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

4. Sex Male 5. Color or race 2 cae 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 25 1924
(Month) (Day) (Year)

8. AGE: Years 15 Months 0 Days 17 If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business P.D. Seorge. Paint Co.

12. Name John T. Evers

13. Birthplace Chicago Ill. (City, town, or county) (State or foreign country)

14. Maiden name Ella I. mas. Howard

15. Birthplace Columbus Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Maggie Stevenson

(b) Address 720 W. State St. Chicago Ill.

17. (a) (b) Date thereof May 15 - 44
(Month) (Day) (Year)

(c) Place: burial or cremation Chicago Ill.

18. (a) Signature of funeral director C. J. Young

(b) Address 2620 Lanyon Blvd

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 17
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 99
(d) Street No. 420 Cabot ave (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 7 year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Meningeal Fracture of Skull when he was kicked by a horse at 625 Halcyon ave and 78th
Due to April 17-44

Due to _____

Other conditions _____

Major findings: _____

Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) Accident 1000

(b) Date of occurrence 4-17-44

(c) Where did injury occur? St Louis (City or town) (County) (State) MO

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Accident
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. Z. Brudeck (Registrar's signature) Address 1066 Clark Date signed 5/1/44

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

MOTHER FATHER

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

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

Clark Young

Licensed Embalmer No.

3371

P. O. Address

St. James

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.