

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

**FILED** NOV 23 1945  
Registration District No. **318**

Primary Registration District No. **1003**

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17  
9

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
De Paul Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 HOUR  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ferguson,  
(If outside city or town limits, write "RURAL")

(d) Street No. Clearview Drive Box 715  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Benjamin E. Evers

(b) If veteran, name war No

(c) Social Security No. 489-07-9442

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6th  
year 1945 hour 11 minute 30P M.

21. I hereby certify that I attended the deceased from Aug 17  
1945 to 11-6 1945  
that I last saw him alive on 11-6 1945  
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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 September 1, 1878  
(Month) (Day) (Year)

Immediate cause of death Pulmonary edema

Due to arterial stenosis

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

Other conditions (Include pregnancy within 3 months of death) 92

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

Of autopsy as above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>2</u>	<u>5</u>	hr. _____ min. _____

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

10. Usual occupation Packer

11. Industry or business Elder Shirt Co.

12. Name Wm. Evers

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

14. Maiden name Minnie Feldmann

15. Birthplace St. Louis  
(City, town, or county) (State or foreign country)

16. (a) Informant August F. Meier

(b) Address 4519 N. Union Blvd.

17. (a) Burial (b) Date thereof Nov. 10 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Paschedag-Henke Fun. Home

(b) Address 2825 N. Grand Blvd.

19. (a) NOV 8 1945 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 Home

23. Signature W J Chynoweth (M. D. or other) ml

Address 4991 Thrush Date signed 11-8-45

**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..... *W. Wilkerson*  
Licensed Embalmer No..... *3575*

P. O. Address.....

**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.**