

FILED JAN 21 1946

Registration District No. Primary Registration District No.

1003

Registrar's No. 127

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:
Enroute to Homer Phillips
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3145th Lucas Ave
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Wayman H. Stevens

3. (b) If veteran, name war..... 3. (c) Social Security No. 492-037741

4. Sex Male 2 5. Color or race ca
 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Dollie 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Jan 19th 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 11 12 hr. min.

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

10. Usual occupation Salesman

11. Industry or business.....

MOTHER, FATHER

12. Name Walter Stevens

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

14. Maiden name Caroline Green

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

16. (a) Informant Dollie Stevens

(b) Address 3145th Lucas Ave

17. (a) Burial (b) Date thereof 1-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. F. Bredeek

(b) Address 3133 Bell Ave

19. (a) 7 1946
(Date received local registrar) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 12
year 1946 hour 8 minute 15 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 External laceration of
from gunshot wound of heart
superficial wound given in the
chamber of one Joseph Horton Cole
Wayman Stevens (Cole) advanced
topical gun youth & knife in his
chamber in the home 3307 Lucas
St. Louis Mo 8:15 P.M. Jan 1, 1946

Other conditions.....
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations 168
 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) Festive Dinner

(b) Date of occurrence Jan 1, 1946

(c) Where did injury occur? at home
(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 knife

23. Signature James E. Taylor (M. D. or other) M.

Address 167 W. Bell Ave Date signed 1/7/46

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

S. J. Sharts
.....
Licensed Embalmer No. *269A*

P.O. Address *2769 Charlotte*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 127

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

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

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

7. Birth date of deceased. Jan 19 (Month) 19 (Day) 1946 (Year)

8. AGE: Years 44 Months Days If less than one day hr. min.

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

10. Usual occupation Baker moving & storage

11. Industry or business.....

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) (Date received local registrar) (b) J. F. Brudeck

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..... Day..... Year 1946 Hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
 that I had seen..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Exclude 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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

3165

JAN 31 1946

982