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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 7 1948

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 1851

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: City Infirmery
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 months
(Specify whether years, months or days)

In this community 60 Years

3. (a) PRINT FULL NAME Michell EVERARD.

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

4. Sex Male 5. Color or race "hite" 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased May 5 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Construction Work

11. Industry or business Retired

MOTHER FATHER { 12. Name Bates Everard 7

13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

14. Maiden name Fannie Pryor 9
(City, town, or county) (State or foreign country)

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

16. (a) Informant City Infirmery Records
(b) Address 5800 Arsenal St.

17. (a) Burial (b) Date thereof 2 26 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. PETER CEMT

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) FFR 25 1948 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 23rd;
year 1946 hour 6:35 minute P.M. M.

21. I hereby certify that I attended the deceased from September 3, 1945 to February 23, 1946;
that I last saw him alive on February 23rd, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vascular Accident
less than one hour

Due to Previous Cerebral Hemorrhage

Due to with phychosis 2 years

Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____
(Specify type of place) (c) Means of injury

23. Signature Palmer P. Brown (M. D. or other) _____
Address 5800 Arsenal St Date signed 2-24-46

WRITE PLAINLY—USE UNFADING 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 *Clavin D. Mc Dermott*

Licensed Embalmer No. *3024*

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.