

No. 1
-17-39
X36871

FILED JUN 13 1946
Registration District No. **308**

Primary Registration District No. **6257**

Registrar's No. **11**

1. PLACE OF DEATH:
(a) County **W. Payne**
(b) City or town **Poplar Bluff**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Lost Creek Hosp. 3**
(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 **Gas**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6809 Dale Ave** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **PATRICIA ANN McEVoy**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **FEMALE** **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 **SEPT 11 1932**
(Month) (Day) (Year)

8. AGE: Years **13** Months **8** Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation **STUDENT**

11. Industry or business _____

12. Name **John McEvoy**
13. Birthplace **St. Louis Mo. 11**
(City, town, or county) (State or foreign country)

14. Maiden name _____
15. Occupation **GENEVIEVE JUDGE**
(City, town, or county) (State or foreign country)
16. (a) Informant **MR. GENEVIEVE DEWICK**
(b) Address **6809 DALE AVE**

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof **5/15/46**
(Month) (Day) (Year)
(c) Place: burial or cremation **CALVERY**
18. (a) Signature of funeral director **M. J. Clayton**
(b) Address **7146 MADISON ST.**

19. (a) May 17, 1946 (Date received local registrar) (b) **Mabel Beasley** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **11**
year **1946** hour **2** minute **10 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 **accidental**
Drowning
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy **none**
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) **accident 111**
(b) Date of occurrence **May 11, 1946**
(c) Where did injury occur? **Shook Wave Pool**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on Lake Wappapell
While at work? **No** (Specify type of place) (Mans of injury)
23. Signature **Miss S. Marshall** (M.D. or other) **Colonel**
Address **Greenfield** Date signed **5/24/46**

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

MOTHER FATHER

BASE JUN 7 1946

RECEIVED

District Health Officer No. 4
District File Number 646-2163
Date Filed 6-1-46

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 Wallace N. Fitch

Licensed Embalmer No. 3859

P. O. Address Poplar Bluff, Mo

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. 370

Primary Registration District No. 6251

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Wayne Rural
(b) City or town _____
(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 Patricia A. McEvey
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Sept 11
(Month) (Day) (Year)

8. AGE: Years 13 Months 0 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

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? _____

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

19322