

#93384

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 265
265

FILED JAN 19 1949

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (in this place) township) 2 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 5019 Arlington	

3. NAME OF DECEASED (Type or Print) a. (First) HARRY	b. (Middle) H.	c. (Last) EVERING	4. DATE OF DEATH (Month) (Day) (Year) Jan. 9th, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan. 30, 1884	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Maker		10b. KIND OF BUSINESS OR INDUSTRY Smoking Tobacco		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME William Evering	13b. MOTHER'S MAIDEN NAME Sophia Poertner	14. NAME OF HUSBAND OR WIFE ---
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 494-09-6408	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ludwig Wagner, 5019 Arlington	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tubo-paresis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Syphilis		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
19a. DATE OF OPERATION			

19b. MAJOR FINDINGS OF OPERATION	21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from 1/6/49, 1949, to 1/9/49, 1949, that I last saw the deceased alive on 1/9/49, 1949, and that death occurred at 3:00 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William W. Carter M.D.	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 1/10/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 12, 1949	24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REGISTRY JAN 10 1949	REGISTRAR'S SIGNATURE J. P. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F. HOME, INC., 1936 St. L. Ave.	ADDRESS
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WRITE PLAINLY--USING UNFADING BLACK 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 _____

..... Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed Walter Paulson

Licensed Embalmer No. 4114

P. O. Address 1936 St. Louis Ave

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.