

No. 300  
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FILED MAR 28 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10919

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1406**

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

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (In this place) <b>24 yrs.</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	<b>2269</b>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Pronounced dead City Hosp.</b>		d. STREET ADDRESS (If rural, give location) <b>p. 26 3711a N. 9 Street 4</b>	

3. NAME OF DECEASED (Type or Print) <b>Evangeline ( Evelyn ) Omersu</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>February 10, 1950</b>		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 12, 1910</b>	9. AGE (In years last birthday) <b>39</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Ellington, MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>G.W. Brewer</b>	13b. MOTHER'S MAIDEN NAME <b>Fannie Brawley</b>	14. NAME OF HUSBAND OR WIFE <b>Mathew Omersu</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>490-22-5881</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mathew Omersu</b>	ADDRESS <b>3711a N. 9 Street</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Sodium Fluoride Poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES <b>self administered in her home at 3711 a No 9th St, on or about Feb 10 1950.</b>		
	DUE TO (b) <b>at 3711 a No 9th St, on or about Feb 10 1950.</b>		
	DUE TO (c) <b>suicide while suffering from temporary mental aberration</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Suicide</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St Louis Mo 49114</b>
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21d. TIME OF INJURY <b>Feb 10 50 ? m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **9:20 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Walter Ross Deputy Coroner 3</b>	23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>2/13/50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Feb. 14, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, MO.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 13 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Laster</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Suedmeyer &amp; Son's</b>	ADDRESS <b>3934 N. 20 Street</b>
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