No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42907

State File No. 11277

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11277

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4220w San Francisco

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY 2101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 10 St. Louis
d. STREET ADDRESS (If rural, give location) 4220w San Francisco

3. NAME OF DECEASED (Type or Print)
a. (First) Anna
b. (Middle) Marie
c. (Last) Evers

4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1951

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 9, 1871
9. AGE (In years last birthday) 80 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Link
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Fred Evers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Fred Evers, 4220w San Francisco ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arterio-sclerosis — 4 years
DUE TO (c)

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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4221

22. *I hereby certify that I attended the deceased from* June 10th, 1944, *to* Dec 19th, 1951, *that I last saw the deceased alive on* Dec 18th, 1951, *and that death occurred at* 10:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] M.D.
23b. ADDRESS 220 - N. 4th St
23c. DATE SIGNED 12/20/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE 12/21/51
24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory
24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri

DATE REC'D BY LOCAL REG. DEC 20 1951
REGISTRAR'S SIGNATURE [signature] M.D.
25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 N. Grand Blvd. ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.