

MAY 27 1952

STANDARD CERTIFICATE OF DEATH

State File No. **18891**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1285**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bellefontaine Neighbors		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bellefontaine Neighbors 40 20	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Training School		d. STREET ADDRESS (If rural, give location) 10695 Bellefontaine Road	

3. NAME OF DECEASED (Type or Print) EVELYN	a. (First)	b. (Middle)	c. (Last) ADAMS	4. DATE OF DEATH (Month) (Day) (Year) May 14 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH October 18, 1921	9. AGE (In years) (Month) (Day) 30 6 26	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Edward Adams	13b. MOTHER'S MAIDEN NAME Elizabeth Grammer	14. NAME OF HUSBAND OR WIFE /
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Records of St. Louis State Jr. School	ADDRESS 10695
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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) Acute Gastritis with Hemorrhage		MEDICAL CERTIFICATION Resident Physician Conry, R. J.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental deficiency, Ortho Paraplegia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 543A	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from **May 13**, 19**52**, to **May 14**, 19**52**, that I last saw the deceased alive on **May 14**, 19**52**, and that death occurred at **10:28 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Edward P. M... M.D.	23b. ADDRESS 10695 Bellefontaine Road	23c. DATE SIGNED 5/14/52
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24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Removal	24b. DATE May 16, 1952	24c. NAME OF CEMETERY OR CREMATORY MT. HOPE	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.
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DATE REC'D BY LOCAL REG. 5-16-52	REGISTRAR'S SIGNATURE Herbert R. Dombke MD	25. FUNERAL DIRECTOR'S SIGNATURE McLAUGHLIN FUNERAL HOME-2301 LAFAYETTE	ADDRESS SW
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Yanni R. Chapman*
Licensed Embalmer No. *4550*
P. O. Address *St. Louis, 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.