

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10013**
2394
Registrar's No.

BIRTH NO. **FILED MAR 25 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 Missouri b. COUNTY 2129	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital		d. STREET ADDRESS (If rural, give location) 12 5351 Delmar Blvd.	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) H. c. (Last) EVANS			4. DATE OF DEATH (Month) (Day) (Year) March 14, 1954		
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5. SEX M.	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 W Divorced	8. DATE OF BIRTH 12-26-1883	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 2 Days 18	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY STREET CAR CO		11. BIRTHPLACE (City and State or Foreign Country) Stoutland, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME John Evans		13b. MOTHER'S MAIDEN NAME Delilah Traw		14. NAME OF HUSBAND OR WIFE Hanna Sudsmeyer	
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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 # 493-10-7987		17. INFORMANT'S SIGNATURE OR NAME Masonic Home of Mo. 5351 Delmar Blvd.		ADDRESS 5351 Delmar Blvd.	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Tongue				INTERVAL BETWEEN ONSET AND DEATH 8 months	
		ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. 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 <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) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 141X	
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22. I hereby certify that I attended the deceased from **6-16, 1952**, to **3-14, 1954**, that I last saw the deceased live on **3-14, 1954**, and that death occurred at **8:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert Brunsford M.D.		23b. ADDRESS 508 North Grand		23c. DATE SIGNED 3-15-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-17-54		24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
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DATE REC'D BY LOCAL REG. MAR 16 1954		REGISTRAR'S SIGNATURE JAY B. SMITH		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B. SMITH, Maplewood, Mo.	
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2028 NOV 23 1954

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 W. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.