No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39378

BIRTH NO. 80369-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10187

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): Saint Louis Maternity

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
STREET ADDRESS (If rural, give location): 1902 Belt Avenue

3069

3. NAME OF DECEASED (Type or Print)
a. (First)
b. (Middle)
c. (Last): Evil

4. DATE OF DEATH (Month) (Day) (Year): October 26 1956

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: October 26 1956
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 12 Min. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (City and State or Foreign Country): St Louis Missouri 0
12. CITIZEN OF WHAT COUNTRY?: --

13a. FATHER'S NAME: Amos Evil
13b. MOTHER'S MAIDEN NAME: Elsie Marie Nave
14. NAME OF HUSBAND OR WIFE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S SIGNATURE OR NAME: Elsie Marie Evil
ADDRESS: Above

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) Premature birth (20 wks) — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) incompatible with life.

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: 776X
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?

22. *I hereby certify that I attended the deceased from* Oct 26, 1956, *to* Oct 26, 1956, *that I last saw the deceased alive on* 6:40 P, 1956, *and that death occurred at* 9:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Frank B. Long MD 0
23b. ADDRESS: 100 N. Euclid
23c. DATE SIGNED: 10/29/56

24a. BURIAL, CREMATION, REMOVAL (Specify): 11-30-56
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: NOV 8 1956
REGISTRAR'S SIGNATURE: Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE: Rowland-Akers
ADDRESS: 4104 Manchester

m 83 (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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.