

pt. Health,  
r. & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI 87003-57  
STANDARD CERTIFICATE OF DEATH

45792  
STATE FILE NUMBER  
12037  
Registrar's No.

FILED DEC 30 1957

Registration District No. 318 Primary Registration District No. 1003

S. 300  
ev. 1-57

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b><br>b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>ST. LOUIS MO</b>      |  | c. CITY OR TOWN <b>ST LOUIS</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>1422 Blair</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>25 1422 BLAIR</b>  |  |

|   |                               |   |  |   |  |
|---|-------------------------------|---|--|---|--|
| 3. NAME OF DECEASED<br>(Type or print) <b>BETTY JEAN EVANS</b>  |                               |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>11</b> Year <b>57</b> |   |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>NEGRO</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>10 27 - 57</b>                               |   | 9. AGE (In years last birthday) <b>1</b> MONTHS <b>11</b> DAYS <b>17</b> |
| 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 country) <b>ST LOUIS MO</b> |  |
| 13a. FATHER'S NAME <b>EASIE NOIL</b>  |                               |   | 13b. MOTHER'S MAIDEN NAME <b>DENNIE L. EVANS</b>                 |   | 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 Address <b>BENNIE EVANS 1422 BLAIR.</b>         |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Suffocation</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |
| DUE TO (b) _____<br>DUE TO (c) _____  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

|  |  |   |  |
|--|--|---|--|
| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18)<br><b>While found in bed at home on December 11, 1957.</b> |  |
| 20c. TIME OF INJURY<br>Hour <b>12</b> Month, Day, Year <b>11 57</b><br>a.m. p.m.                                     |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>25 Home</b>              |  | 20f. CITY, TOWN, OR LOCATION <b>St Louis MO</b> COUNTY STATE  |  |

|   |                                |
|---|--------------------------------|
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____<br>Death occurred at <b>545 PA</b> on _____ date stated above; and to the best of my knowledge, from the causes stated. |                                |
| 22a. SIGNATURE (Degree of _____)<br><b>Regina L. Smith</b>  | 22b. ADDRESS <b>1300 Chest</b> |
| 22c. DATE SIGNED <b>12/16/57</b>  |                                |

|   |                           |  |  |
|---|---------------------------|--|--|
| 23a. BURIAL, CREATION, REMOVAL (Specify)                            | 23b. DATE <b>12-16-57</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>OAK DALE</b> | 23d. LOCATION (City, town, or county) (State) <b>LEMAH, MO</b> |
| 24. FUNERAL DIRECTOR ADDRESS <b>DENT &amp; BRESSLER 3404 DELMAR</b> |                           | 25. DATE RECD. BY LOCAL REG. <b>DEC 16 57</b>      | 26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>                 |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE 27030

MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed *Leroy W. Fannist* .....

Licensed Embalmer No. *4523*  
P. O. Address *4251 Washing*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.