

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024135  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1634

FILED JUL 11 1958

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS COUNTY</u>		c. CITY OR TOWN <u>Jennings 40000</u>		
Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Halls Ferry Home</u>		d. STREET ADDRESS (If outside, give location) <u>4471 Central Av.</u>		
Length of stay in lb <u>1 Mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ada</u> Last <u>Evans</u>			4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state of country) <u>St. Louis County, Mo.</u>	
13a. FATHER'S NAME <u>James L. Evans</u>		13b. MOTHER'S MAIDEN NAME <u>Urania Harton</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		17. INFORMANT Address <u>Miss Mabel B. Evans 4471 Central</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage - Rt Side Paralysis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>3-2-58</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>3-2-58</u> to <u>6-17-58</u> and last saw her alive on <u>6-17-58</u> Death occurred at <u>9:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Ray Johnson M.D.</u>		22b. ADDRESS <u>40 N. Florissant Rd.</u>		
22c. DATE SIGNED		23a. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		
23b. DATE <u>6/19/58</u>		23c. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
23d. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		24. FUNERAL DIRECTOR <u>White-Mullen 118 N. Florissant Rd.</u>		
24. ADDRESS <u>118 N. Florissant Rd.</u>		25. DATE RECD. BY LOCAL REG. <u>6-18-58</u>		
26. REGISTRAR'S SIGNATURE <u>Herbert R. Danke M.D.</u>		27. (Licensed Embalmer's Statement on Reverse Side)		

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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6.0.0

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 Eleanora

Licensed Embalmer No. 3403  
P. O. Address Quincy 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.