Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002914
STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 246

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis City Hosp. #1 — Length of stay in 1b: 15 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1729 Dolman — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Rose — Middle: Leona — Last: Evans

4. DATE OF DEATH: Month: Jan. — Day: 7 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: July 5, 1909

9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: Ladies Ready to Wear

11. BIRTHPLACE (City and state or country): Ste. Genevieve Co., Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Tony Evans

13b. MOTHER'S MAIDEN NAME: Nora Robert

14. NAME OF HUSBAND OR WIFE: Frank Litterst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 497-20-4220

17. INFORMANT: Madeline Townes, 1729 Dolman — Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gastro intestinal hemorrhage	24 hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Uremia	2 wks.
DUE TO (c)	Chronic nephritis 581.1	2+ years.

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 [ ] NO [/]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 Nov. 16, 1958, to Jan. 7, 1959 and last saw her/him alive on Jan. 7, 1959
Death occurred at 12:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Anton M. Farage, M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 1/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 1-8-59

23c. NAME OF CEMETERY OR CREMATORY: Crest Lawn Cemetery

23d. LOCATION (City, town, or county) (State): Ste. Genevieve, Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe — ADDRESS: 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: JAN 8 '59

26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

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 Robert M. Murray

Licensed Embalmer No. 3749

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

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