

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015938

STATE FILE NUMBER

2586

FILED MAY 1 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Massac</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Metropolis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>1021 Pearl St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle _____ Last <b>Whalen</b>			4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1907</b>		9. AGE (In years to birthday) <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>McCracken Co., Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>J. R. Baynes</b>		13b. MOTHER'S MAIDEN NAME <b>Nellie James</b>		14. NAME OF HUSBAND OR WIFE <b>Leon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Leon Whalen Metropolis, Illinois</b> Address <b>1021 Pearl St.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b>			INTERVAL BETWEEN ONSET AND DEATH <b>about 3 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1930</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.			20d. INJURY OCCURRED WHILE AT <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 **2-26-59** to **3-11-59** and last saw <sup>her</sup>him alive on **3-11-59**  
Death occurred at **11:25 pm** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Francis J. Nash, M.D.</b> (Degree or title)		22b. ADDRESS <b>100 No EUCLID, ST. LOUIS, Mo</b>	22c. DATE SIGNED <b>3-12-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-13-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>METROPOLIS, ILL.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 13 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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Health, Welfare, Public Service

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.

Medical Certification  
 Use only black ink or ribbon typewrite if possible  
 Quaid: Madeleine

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 *Samuel O. Gabeling*

Licensed Embalmer No. .... *4979*  
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.