

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016190

STATE FILE NUMBER

FILED MAY 8 1959

Registration District No. 317

Primary Registration District No. 547

Registrar's No. 1157

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. John 4051</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in 1b <b>7 wks.</b>	d. STREET ADDRESS (If outside, give location) <b>8688 Belhaven Dr.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>T.</b> Last <b>Vallat</b>			4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>59</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>Jan. 8, 1920</b>	9. AGE (In years last birthday) <b>39</b>	10. F UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
-------------------------	----------------------------------	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Secretary-Ret.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hosp.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	---	---	---

13a. FATHER'S NAME <b>George E. Erfer</b>	13b. MOTHER'S MAIDEN NAME <b>Magdalane Frank</b>	14. NAME OF HUSBAND OR WIFE <b>Herbert J. Vallat</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>unk.</b>	17. INFORMANT <b>Mr. Herbert J. Vallat</b> Address <b>8688 Belhaven Dr.</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>Lymphatic Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 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>2040</b>		19. 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.) <b>2040</b>
---	---

20c. TIME OF INJURY Hour _____ 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.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--	--

21. I attended the deceased from <b>March 13, 59</b> to <b>April 25, 59</b> and last saw her alive on <b>April 25, 1959</b> Death occurred at <b>7:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>Martin G. Austin MD</b> (Degree or title)	22b. ADDRESS <b>634 N Grand Blvd</b>	22c. DATE SIGNED <b>4-27-59</b>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4/28/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>	ADDRESS <b>1905 Union</b>	25. DATE RECD. BY LOCAL REG. <b>4-28-59</b>	26. REGISTRAR'S SIGNATURE <b>John P. Murphy M.D.</b>
--	------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Martin G. Austin  
634 N. Grand  
Je. 1-5521

Hrs. 1 - 3 PM  
2:30

CALL BEFORE GOING

### 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 Warren A. Carver

Licensed Embalmer No. 353

P. O. Address .....

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.