

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019142

STATE FILE NUMBER

2 4731

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JUN 1 1959

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY WASHINGTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN NASHVILLE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 207 WEST SMITH	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last EVILSIZER		4. DATE OF DEATH Month MAY Day 13 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 16, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL	11. BIRTHPLACE (City and state or country) NASHVILLE
13a. FATHER'S NAME JOHN C. EVILSIZER		13b. MOTHER'S MAIDEN NAME MELISSA GRAHAM	14. NAME OF HUSBAND OR WIFE ELLA EVILSIZER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 344-01-5570	17. INFORMANT Address Ella Evilsizer 207 WEST SMITH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX WITH METASTASES TO LUNG			INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) POST-OPERATIVE RIGHT LOWER LOBE LOBECTOMY			
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.) 161x	
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 MAY 1, 1959 to MAY 13, 1959 and last saw her alive on MAY 13, 1959 Death occurred at 4:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. D. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 17, 1959	
23c. NAME OF CEMETERY OR CREMATORY MASONIC		23d. LOCATION (City, town, or county) (State) NASHVILLE ILL.	
24. FUNERAL DIRECTOR ADDRESS Shall Gonzoski E. ST. LOUIS, ILL.		25. DATE RECD. BY LOCAL REG. MAY 15 '59	
		26. REGISTRAR'S SIGNATURE Lois Smith, M.D.	

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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 not embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John A. Gzonoski
Licensed Embalmer No. 6421
P. O. Address St. Louis

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.