

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026611

FILED VS JUL 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-6698** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY _____		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 2 DAYS	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1843 KENNET PL.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Maggie Middle Evans Last _____			4. DATE OF DEATH Month July Day 16 Year 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH AUG. 4, 1910	9. AGE (last birthday) 48 YRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) TENNESSEE	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME DALTON DAVISON		13b. MOTHER'S MAIDEN NAME MOLLIE ESSEX		14. NAME OF HUSBAND OR WIFE CHARLES EVANS	
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. UNKNOWN	17. INFORMANT Address Charles Evans, 1843 Kennett Pl.		
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) COMPRESSION OF LOW CERVICAL SPINAL CORD					3 DAYS
DUE TO (b) PATHOLOGIC FRACTURE OF LOW CERVICAL VERTEBRA					3 DAYS
DUE TO (c) ARTHRITIS, RHEUMATOID, OF SPINE, SEVERE					18 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)			
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 checked="" 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 July 14, 1959 to July 16, 1959 and last saw her/him alive on July 16, 1959 Death occurred at 7:22 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert W. Moellenhoff M.D.			22b. ADDRESS 1515 Lafayette		22c. DATE SIGNED 7/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-19-59	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) East Prairie, Mo.	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. JUL 17 '59	26. REGISTRAR'S SIGNATURE Keal Smith, M.D., R.P.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 27 1959

Wenzel

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Harvey Kable

Licensed Embalmer No. 4596

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.