

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 046154

FILED VS JAN 11 1960

STATE FILE NUMBER 9525

ENDED

Registration District No. 319 Primary Registration District No. 541 Registrar's No. 9525

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b <u>D.O.A.</u>		c. CITY OR TOWN <u>MEHLVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS COUNTY HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>670 SUSAN RD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD D. EVANS</u>				4. DATE OF DEATH Month Day Year <u>DEC - 30 - 1959</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-22-1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CHIROPODIST</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>DANIEL EVANS</u>			13b. MOTHER'S MAIDEN NAME <u>CLARA HELLWIG</u>			14. NAME OF HUSBAND OR WIFE <u>MARIE A. EVANS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>MRS MARIE A EVANS</u>		Address <u>670 SUSAN RD ST LOUIS 29 MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>old cerebro-vascular thrombosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.) <u></u>					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>							
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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u>		STATE <u></u>	
21. I attended the deceased from <u>1958</u> to <u>1959</u> and last saw ^{her} him alive on <u>12-22-59</u> Death occurred at <u>1:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>R. J. Hoff Laller M.D.</u> (Degree or title)				22b. ADDRESS <u>16 Hampton Village Pl.</u>			22c. DATE SIGNED <u>12/30/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN-2-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>		23d. LOCATION (City, town, or county) <u>FLEETON MO</u>		(State) <u></u>	
24. FUNERAL DIRECTOR <u>Fey Funeral Home, MEHLVILLE MO</u>				25. DATE RECD. BY LOCAL REG. <u>12-31-59</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Murphy M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Clarence M. Bill

Licensed Embalmer No. 4375

St. Louis, 23, MO
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.