

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048153

FILED VS JAN 5 1961

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3798 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give township only) OR TOWN <u>8380 Kinloch</u>	Length of stay in lb	c. CITY OR TOWN <u>KINLOCH</u>	Inside Limits Yes <input 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>		d. STREET ADDRESS (If outside, give location) <u>8380 Kinloch Mo</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Rinnie</u> Middle <u>EVANS</u> Last <u>EVANS</u>	4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>60</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>July 4, 1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or country) <u>Lockhart Miss</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Robert Paine</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Cook</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Evans</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Walter Evans 8380 Kinloch St. Louis Mo</u>
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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>Acute myocardial insufficiency</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephritis</u>	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
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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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m.	Month, Day, Year
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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 <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
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21. I attended the deceased from 12-28-60 to 12-29-60 and last saw her alive on 12-29-60  
Death occurred at 7:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <u>Walter L. Howe M.D.</u> (Degree or title)	22b. ADDRESS <u>6015 Brentwood, Clayton 5, Mo.</u>	22c. DATE SIGNED <u>12/29/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Jan 5, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis County Mo</u>
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24. FUNERAL DIRECTOR <u>F. A. Hean 4214 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>12-31-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Mayhew M.D.</u>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963  
P. O. Address 4214 Delmar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.