

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-008013**

STATE FILE NUMBER

**318**

**1003**

**1753**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**FILED FEB 23 1962**

AMENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Length of stay in 1b		c. CITY OR TOWN <b>Washington</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. LOUIS CITY HOSP. #1.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1308 Clifton St. N.W.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>MABELLE</b> Middle <b>H.</b> Last <b>EVANS</b>				4. DATE OF DEATH <b>FEB. 10, 1962</b> Month Day Year									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau.</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-21-83</b>		9. AGE (last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (City and state or country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>John J. Evans</b>				13b. MOTHER'S MAIDEN NAME <b>Catherine Jenkins</b>				14. NAME OF HUSBAND OR WIFE <b>None</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.		17. INFORMANT Address <b>Harriett Evans 1731 Simpson Place</b>							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
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.) <b>331x</b>									
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 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>2/8/62</b> to <b>2/10/62</b> and last saw her/him alive on <b>2/10/62</b> Death occurred at <b>5:05 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>David T. Smith M.D.</i> (Degree or title)						22b. ADDRESS <b>1515 LAFAYETTE</b>			22c. DATE SIGNED <b>2-10-62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-12-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East Avenue Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>New Philadelphia, Ohio</b>					
24. FUNERAL DIRECTOR <b>McLaughlin 2301 Lafayette Ave.</b> St. Louis, Missouri					25. DATE RECD. BY LOCAL REG. <b>2-10-1962</b>		26. REGISTRAR'S SIGNATURE <i>David Smith M.D.</i>						

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

**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 James R. Chapman  
Licensed Embalmer No. 4530  
P. O. Address H. Lavin, Md.

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.