WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC 11 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

41274
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 10966

(c) City St Louis Mo (d) Street No. BARNES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 159 Nellie May Evans

(a) Residence, No. 4593a Garfield ave St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem.
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Harvey Evans

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 6 1877

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
61		11	11	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. House Wife
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Missouri

FATHER
13. NAME James Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Vina Brooks
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Harvey Evans 4593a Garfield

18. BURIAL, CREMATION, OR REMOVAL
PLACE Father Dickson DATE 12-21-38 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russell Und Co. 2732 Pine St.

20. FILED DEC 21 1939 19 J D Biedeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 17, 1938

22. I HEREBY CERTIFY, That I attended deceased from 12-5-, 1938, to 12-17-, 1938.
I last saw her alive on 12-17-, 1938. Death is said to have occurred on the date stated above, at 10 40 P.M.
The principal cause of death and related causes of importance were as follows:

Peritonitis following laparotomy, ac. infectious Perforated intestine and bladder, ~~[illegible]~~, operative Broncho Pneumonia

Date of onset

Other contributory causes of importance:
Decompensated heart, Rheumatic (?)
Operation for intestinal obstruction
Myoma of uterus non malignant

Name of operation Date of 12-8-38
What test confirmed diagnosis? Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Ezra L. Evans, Jr., M. D.
(Address) BARNES HOSPITAL

(Licensed Embalmer's Statement on Reverse Side)

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 .....,

Registered Apprentice No....., working under my personal supervision.

Signed Joel Russell

Licensed Embalmer No. 2215

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 this body is not embalmed, above space should be left blank.