

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41928
Registrar's No. 11051

Registration District No. 2000 Primary Registration District No. _____

1. PLACE OF DEATH: 1
 (a) County _____
 (b) City or town St. Louis, Missouri
 (c) Name of hospital or institution City Hospital, #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Stillborn
 In this community Stillborn (Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Evans 15
 3. (b) If veteran, name war X 3. (c) Social Security No. X
 4. Sex unknown 5. Color or race White 6. (a) Single, widowed, married, divorced X
 6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased December 19, 1939
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Stillborn

9. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business X

MOTHER FATHER
 { 12. Name Earl Evans
 { 13. Birthplace Missouri
 { 14. Maiden name Margaret Scott
 { 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Morrison
 (b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 12/28/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place of burial or cremation City Crematory

18. (a) Signature of funeral director Richard Vane Toppau
 (b) Address City Hosp #1

19. (a) DEC 27 1939 (b) J. J. [Signature]
 (Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County X
 (c) City or town St. Louis 26
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1517 Palm
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. X years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19,
 year 1939 hour 4:30 minute A. M.
 21. I hereby certify that I attended the deceased from December
19, 1939 to December 19, 1939
 and that I last saw him alive on December 19, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Stillborn
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations None
 Of autopsy None

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? (City or town) (County) (State) _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) _____
 (e) Means of injury _____
 23. Signature [Signature] (M. D. or other)
 Address 1515 Lafayette 12/21/39
 Date signed

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.....

Licensed Embalmer No.....

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.