

FILED SEP 8 1944

Primary Registration District No. 1003

Registrar's No. 7512

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
DePaul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 18 Days
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME..... Ruth R. Evers

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife..... Theo J. Evers 6. (c) Age of husband or wife if alive..... 65 years

7. Birth date of deceased..... September 13 1892
(Month) (Day) (Year)

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

51 11 16 hr. min.

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

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Joseph Reid 9

13. Birthplace..... Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name..... Matilda Dunnell

15. Birthplace..... Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant..... Theo J. Evers

(b) Address..... 4755 Cote Brilliante Ave

17. (a) Cremation (b) Date thereof..... Aug 30 '44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Valhalla Crematory

18. (a) Signature of funeral director..... Kraeger-Voss-Fix

(b) Address..... 3402 No. Kingshighway

19. (a) AUG 30 1944 (b) J. F. Brebeck
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000

(c) City or town..... St. Louis 126
(If outside city or town limits, write "RURAL") 96

(d) Street No..... 4755 Cote Brilliante
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29
year..... 1944 hour 2:10 minute 0 M.

21. I hereby certify that I attended the deceased from.....
Dec 9, 1943 to August 29, 1944

that I last saw him alive on..... Aug 29, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death..... Chronic Myocarditis Duration 3 yrs
D. C. I. D. (Chronic Cardiac) Valvular Disease 3 yrs
Remittent Fever 3 yrs

Due to.....

Due to.....

Other conditions..... Peptic Ulcer 12 yrs
(Include pregnancy within 3 months of death) Stroke

Major findings:
Of operations..... Pleural Effusion

Of autopsy.....

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?.....

(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... Richard J. Ginnell, M.D. (M. D. or other)

Address..... 5146 St. Louis Ave Date signed 8-29-44

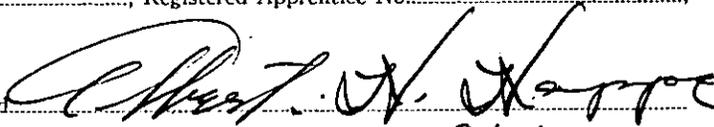
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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..... 1861

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, fact should be so stated above.