

No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39315**
Registrar's No. **10881**

FILED DEC 21 1964
318

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

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

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether in this community _____ years, months or days)

3. (a) PRINT FULL NAME Della Evans

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex female

5. Color or race Colored

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 22 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace STRAY HORN MISS.
(City, town, or county) (State or foreign country)

10. Usual occupation SEAMSTRESS.

11. Industry or business NONE.

MOTHER FATHER { 12. Name HARRIS.

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

14. Maiden name JOANNA WILLIAMS

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

16. (a) Informant Asa Priestly

(b) Address 4207 Finney

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Dec. 23 49
(Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK Cem.

18. (a) Signature of funeral director Boyd Bros. Funeral Home

(b) Address 3704 Finney Ave.

19. (a) DEC 21 1964
(Date received local registrar)

J. F. Budeck
Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 4207 Finney
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 20,
year 1944 hour 5 minute 55 A. M.

21. I hereby certify that I attended the deceased from December 10,
1944, to December 20,
1944.
that I last saw her alive on December 20,
1944, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Pneumonia
Duration 12 days

Due to _____

Due to _____

Other conditions 18
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Alva Moore (M. D. or other)

Address 2601 W. Hutter Date signed 12/20/44

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

William C. McDowell, Registered Apprentice No.
working under my personal supervision.

Signed *William C. McDowell*

Licensed Embalmer No. *2114*

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.