

No. 2
12-45
-17-39
X47370

FILED DEC 31 1947

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11635**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2618 S. 13th ST. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **EVELYN TIPTON**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **AUG 2 1908**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 4 18 hr. min.

9. Birthplace **ST. LOUIS MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____

12. Name **ALONZO NEWELL**

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

14. Maiden name **FRIEDA SEITZ**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **DOROTHY MICHAELS**

(b) Address **6219 IDAHO**

17. (a) **BURIAL** (b) Date thereof **12-23-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEW ST. MARCUS CEM.**

18. (a) Signature of funeral director **Thos Katis & Son**

(b) Address **2906 Broadway**

19. (a) **DEC 22 1947** **J. F. Brodeur**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **one**
(c) City or town **ST. LOUIS MO 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3316 1/2 ILLINOIS 9**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **20**
year **1947** hour **9:30** minute **A** M.

21. I hereby certify that I attended the deceased from **17 Dec 1947** to **20 Dec 1947**
that I last saw her alive on **12/19/47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Sarcocoma benigna** Duration **6 mo.**

Due to **Metastasis from Kidney Tumor**

Due to **Primary in Kidney**

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

Major findings: **ampul rt thigh - 1928 - sarcocoma & neurectomy for sarcocoma in 1943**

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 **J. Cleary** (M. D. certifier)
Address **1935 Park** Date signed **12/20/47**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Signed.....

Licensed Embalmer No. *4347*

P. O. Address..... *2906 Grand*

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.