

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15661  
Registrar's No. 3955

FILED MAY 14 1953  
BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE Illinois b. COUNTY 8120 Administration)	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN Centralia,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital		e. STREET ADDRESS (If rural, give location) 711 East Broadway	
3. NAME OF DECEASED (Type or Print) Lorraine		4. DATE OF DEATH (Month) (Day) (Year) 4-11-53	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Apr 1, 1903	
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (City and State or Foreign Country) DuBois, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Qualls		13b. MOTHER'S MAIDEN NAME Cliffie Spencer	
14. NAME OF HUSBAND OR WIFE Jefferson C. Evilsizer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME J. C. Evilsizer		ADDRESS Centralia, Ill.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Hypertension		5 years	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. Cyst-adenoma of ovaries		2 years	
19a. DATE OF OPERATION 4/9/53		19b. MAJOR FINDINGS OF OPERATION Exploratory - Extensive peritoneal implants	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		331X <sup>H</sup>	
22. I hereby certify that I attended the deceased from Mar. 24, 1953, to Apr. 11, 1953, that I last saw the deceased alive on Apr. 11, 1953, and that death occurred at 3:15 P.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Harold E. Walters M.D.		23b. ADDRESS 508 N. Grand Blvd.	
23c. DATE SIGNED 4/15/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 4-12-53	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Garnier Centralia, Ill.	
DATE REC'D BY LOCAL REG. APR 16 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Garnier F.H.		ADDRESS Centralia, Ill.	

WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *J. Allen Davis*

Licensed Embalmer No. *4953*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.