

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27645

State File No.

FILED SEP 1 1955

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6840

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3063 Thomas Street		e. STREET ADDRESS (If rural, give location) 3063 Thomas St			
3. NAME OF DECEASED (Type or Print) WILLIE			a. (First)		b. (Middle)
			c. (Last) EVANS		4. DATE OF DEATH Aug 3 1955
5. SEX male		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb 16 1902		9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months 5 Days 17	
11. BIRTHPLACE (City and State or Foreign Country) Shreveport, La		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Thomas Evans		13b. MOTHER'S MAIDEN NAME Sylvest Shelton		14. NAME OF HUSBAND OR WIFE Gertrude Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 489-03-2615		17. INFORMANT'S SIGNATURE OR NAME Gertrude Evans	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Angina Pectoris</u> ANTECEDENT CAUSES <u>Cardiac Asthma</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 30, 1955</u> , to <u>Aug 3, 1955</u> , that I last saw the deceased alive on <u>Aug 3, 1955</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>W.H.G. Clark</u>		(Degree or title) M.D.		23b. ADDRESS 2748a Franklin Ave	
23c. DATE SIGNED 8-5-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug 7 1955	
24c. NAME OF CEMETERY OR CREMATORY Shreveport La		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. AUG 5 1955		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE J.H. Randle & Son	
				ADDRESS 3133 Bell Ave	

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 *S. J. Watson*.....

Licensed Embalmer No. *269*

P. O. Address *2769 Ch*

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.