

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28354

State File No. _____

FILED AUG 29 1955

REG. DIST. NO. 317

PRIMARY REG. DIST. NO. 511

Registrar's No. 1831

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 511		Registrar's No. 1831			
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON</u>		c. LENGTH OF STAY (in this place) <u>D.O.A.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES - 611</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DEADONARIVAL ST. LOUIS COUNTY</u>				d. STREET ADDRESS (If rural, give location) <u>463 PASADENA AV -</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>ELLA</u>		b. (Middle) <u>J.</u>		c. (Last) <u>EVANS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 4, 1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT. 7</u>			
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA.</u>			
11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>DARWIN MAGANN</u>		13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
14. NAME OF HUSBAND OR WIFE <u>WALTER T. EVANS.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO -</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>EARL EVANS, 463 PASADENA AV. W.G. -</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Unknown natural causes</u> ANTECEDENT CAUSES Morbid 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.				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) m.		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Herbert R. Domke, M.D., Local Registrar</u>				23b. ADDRESS <u>651 S. Brentwood Blvd.</u>		23c. DATE SIGNED <u>8-9-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>AUGUST 8, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN CEM -</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>			
DATE REC'D BY LOCAL REG. <u>8/6/55</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Domke, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Wright</u>		ADDRESS <u>831 E. Big Bend</u>			

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

Student Embalmer

Signed

Bill C. Dranson

Licensed Embalmer No. *4769*

P. O. Address *St Louis, Mo.*

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.