

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3622 STATE FILE NUMBER 63-013241

DO NOT WRITE ON THIS STUB

VS 300 Rev. 4/59
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>4962 Northland Ave</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>James</u> Last <u>Evans</u>						4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1963</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-21-1906</u>		9. AGE (last birthday) <u>56</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>				11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Anthony Evans</u>				13b. MOTHER'S MAIDEN NAME <u>Emmaline Davis</u>				14. NAME OF HUSBAND OR WIFE <u>Grace Evans</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.2</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Grace Evans 4962 Northland Ave</u>							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) <u>Cardio Renal Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4427</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>5 weeks</u> <u>months</u> <u>6 months</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from <u>3-27-63</u> to <u>3-27-63</u> and last saw him alive on <u>3-27-63</u> Death occurred at <u>11:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>Caldwell Jones, M.D.</u>						22b. ADDRESS <u>2616 N. Kingshighway</u>				22c. DATE SIGNED <u>3-29-63</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4/1/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>				23d. LOCATION (City, town, or county) <u>Jefferson Barracks, Mo</u>							
24. FUNERAL DIRECTOR <u>C. W. Roberts Und. Co 1416 N. Taylor Ave</u>						25. DATE RECD. BY LOCAL REG. <u>MAR 29 1963</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>							



Handwritten scribbles and illegible text in the left margin.

Handwritten signature of the licensed embalmer.

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 *H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *11237 Taylor*

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.

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