

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2651
Registrar's No. 739

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 2651		Registrar's No. 739		
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 town or township) St Louis				c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St Louis				
d. FULL NAME OF HOSPITAL OR INSTITUTION 4466 SWAN				d. STREET ADDRESS (If rural, give location) 4466 SWAN						
3. NAME OF DECEASED (Type or Print) Elizabeth			a. (First)		b. (Middle)		c. (Last) Everson			
4. DATE OF DEATH			(Month) 1		(Day) 24		(Year) 1949			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Aug 27 1884		9. AGE (In years last birthday) 64		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Cherryville Mo		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE John A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Bernice Fries				ADDRESS 4466 Swan	
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) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c) Cardiovascular disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 4 days		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 5 0 1 10						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) _____		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 1-20, 1949, to 1-23, 1949, that I last saw the deceased alive on 1-23, 1949, and that death occurred at 2:49 a. m., from the causes and on the date stated above.										
23a. SIGNATURE Glenn W. Watterford M.D.				(Degree or title)		23b. ADDRESS 740 So 4th Street		23c. DATE SIGNED 1-24-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-26-1949		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) St Louis County Mo (State)				
DATE RECD BY LOCAL JAN 25 1949		REGISTRAR'S SIGNATURE J. B. Larater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 4104 Manchester					

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.

Signed *Howard F. Rowland*

Signed.....
Student Embalmer

Licensed Embalmer No. 3114

P. O. Address StLouis 10 Missouri.

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.