WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County: Ralls

Township: Jackson
or
Village:
or
City: Madiscomville (NO. ____ St.: ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 723 — File No. 3 — 40394

Primary Registration District No. 3960C — Registered No. 75

FULL NAME Joseph W. Evans

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	married

DATE OF BIRTH Nov. (Month) 6th (Day) 1854 (Year)

AGE 58 yrs. 7 mos. 26 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Pike Co., Mo.

PARENTS
- NAME OF FATHER: Thos. W. Evans
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Pike Co., Mo.
- MAIDEN NAME OF MOTHER: Catharine Butler Evans
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ralls Co., Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James M. Evans

(ADDRESS) Center, Mo, R#1

Filed July 3, 1913. W P Birney, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 2 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan, 1900, to Jan 28, 1913, that I last saw him alive on Jan 28, 1913, and that death occurred, on the date stated above, at 7 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmo

23h 28

(Duration) 13 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. H. Graves M. D.

July 3, 1913. (Address) Center Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Vandalia Mo — DATE OF BURIAL: July 3, 1913

UNDERTAKER: J D Hulse — ADDRESS: Center Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

MISSOURI STATE BOARI
BUREAU OF VITAL ST
CERTIFICATE OF DE

PLACE OF DEATH

County Ralls

Township Jackson
or
Village
or
City (NO. , St.; Ward)

Registration District No. File No.

Primary Registration District No. Registered No.

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH
(Month) (Day) 1 (Year)

AGE
yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

PARENTS
NAME OF FATHER
BIRTHPLACE OF FATHER
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER
BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed , 191 , REGISTRAR

MEDICAL CERTIFICATE OF D

DATE OF DEATH
(Month)

I HEREBY CERTIFY, that I att
, 191 , to
that I last saw h alive on
and that death occurred, on the date state
The CAUSE OF DEATH* was as follows:

(Duration) yrs.

Contributory
(SECONDARY)
(Duration) yrs.

(Signed)
, 191 (Address)

*State the Disease Causing Death, or, in deaths (1) Means of Injury; and (2) whether Accidental, Suicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTI RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL | D

UNDERTAKER | A