

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

Do not use this space.

1. PLACE OF DEATH Dallas Registration District No. 241
 County Dallas 5334 File No. 26853-1a
 Township Washington Primary Registration District No. 265 Registered No. 265-
 (No. 265 St. Ward)
 2. FULL NAME Evans (not named)
 (a) Residence No. St. Ward
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single
 6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, 2 hrs. or min. 2 hrs.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer
 9. BIRTHPLACE (CITY OR TOWN) Buffalo, MO
 (STATE OR COUNTRY)
 10. NAME OF FATHER Albert Evans
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Eva Tomberlin
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) MO
 (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 1927
 17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927 to Sept 30, 1927
 that I last saw him alive on Sept 30, 1927, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Boxed Dead
Premature Birth
15 1/2 @ months
161A

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) B. F. Johnson, M. D.
 , 19 (Address) Buffalo, MO

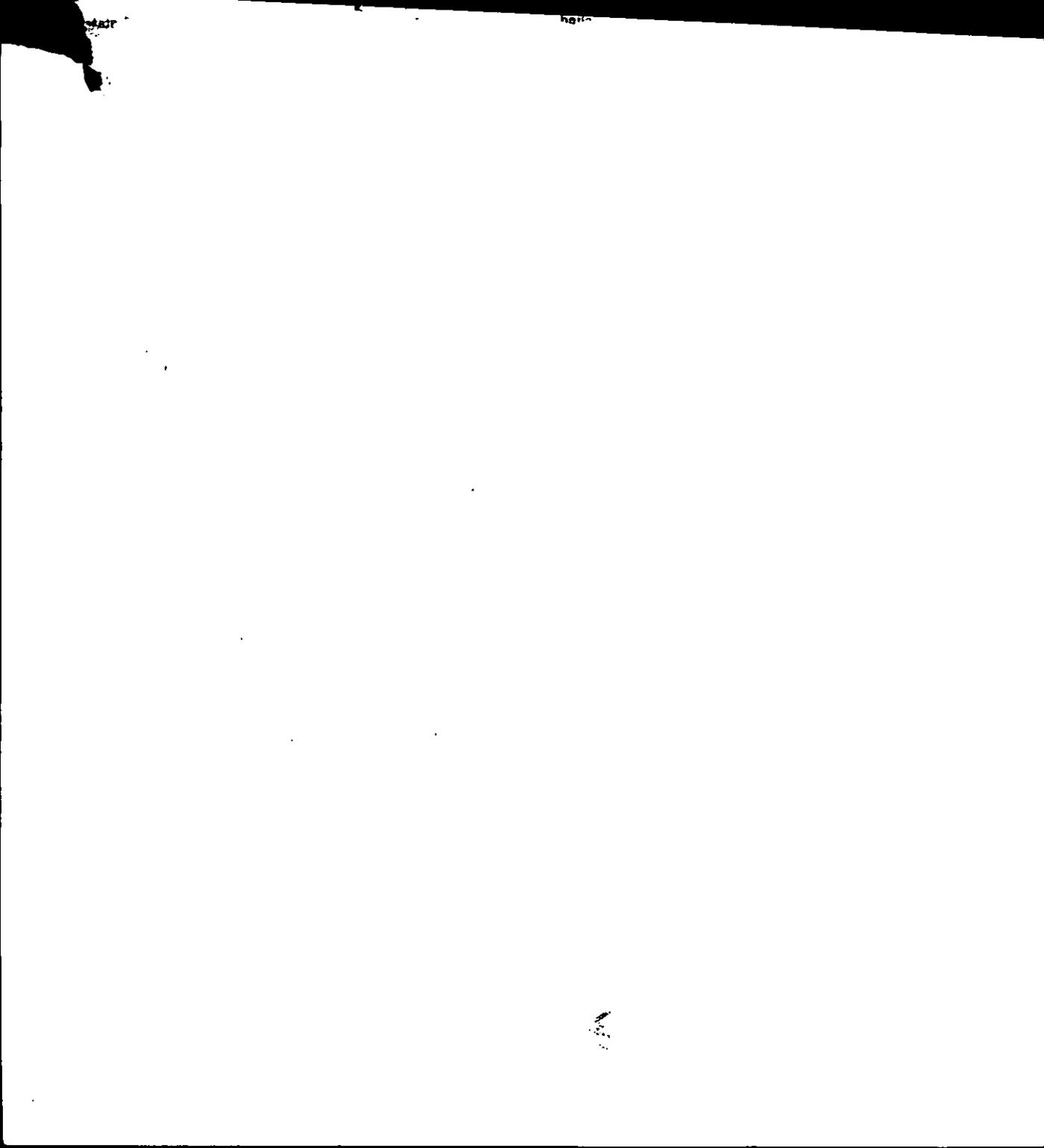
*State the DISEASE CAUSING DEATH, omit deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Wen Shickland 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Schafesed DATE OF BURIAL 1927
 (Address) Buffalo, MO

15. FILED 1/2 1927 H. M. M. M. M. M. REGISTRAR Jack Kump ADDRESS Buffalo

CRUISE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important.

1927



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dallas Registration District No. 241 File No. _____
 Township Benton Primary Registration District No. 5334 Registered No. 265
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Evans (infant)
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) X 07/30-27X

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14.

INFORMANT _____
 (Address)

15.

FILED 11/2 1917 Harvey Williams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30 1927

17. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____, (that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

HESSIP S