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

Do not use this space.

File No. 39419

Registered No. .....

1. PLACE OF DEATH

County: Stone

Township: Ruth

City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 845

Primary Registration District No. 6108

2. FULL NAME: James Evans

(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: Male

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 11 1929

7. AGE: Years ..... Months ..... Days ..... If LESS than 1 day, 1 hrs. or ..... min.

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) (STATE OR COUNTRY): Reeds Spring Mo

PARENTS

10. NAME OF FATHER: Wilfred Evans

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

12. MAIDEN NAME OF MOTHER: Pearl Hornack

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

14. INFORMANT: Pearl Hornack
(Address): Reeds Spring Mo

15. FILED 11/12/ 1929 L. O. Sherrod
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1929, to Nov 11 1929, that I last saw him alive on Nov 11 1929, and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Heart failure
4 poor circulation Marasmus
150
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY): Malnutrition
..... (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) L. O. Sherrod, M. D.
11/12/, 1929 (Address) Reeds Spring Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Yocum Pond Cemetery — DATE OF BURIAL: Nov 12 1929

20. UNDERTAKER: acting Will Tilton — ADDRESS: Reeds Spring Mo

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.

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

104