OCT 28 1930

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

29097

1. PLACE OF DEATH
County: Bates
Township: Spruce
City: (No. ; St. Ward)
Registration District No. 309 366
Primary Registration District No. 3091
File No.
Registered No.

2. FULL NAME: Mary U. Evans
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Married
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Geory H. Evans
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 14, 1858
7. AGE: Years 72; Months; Days 14; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN): ~~Johnson Co~~
(STATE OR COUNTRY): ~~Mo~~

PARENTS
10. NAME OF FATHER: Massy Ferguson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Johnson Co
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Rebecca Zimmerman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): X
(STATE OR COUNTRY): Virginia

14. INFORMANT: J. O. Evans
(Address): Kansas City, Mo

15. FILED Sept 30, 1930 Grace U. Odneal, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 28 1930
17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 27, 1930, that I last saw her alive on Sept 27, 1930, and that death occurred, on the date stated above, at 7.40 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
(duration) 10 yrs. mos. ds
CONTRIBUTORY (SECONDARY)
(duration) 10 yrs. mos. ds
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? physical signs
Sep 28, 1930 (Signed) L. L. Smith, M. D.
(Address) Urich 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bethel Cemetery
DATE OF BURIAL: Sep 29 1930
20. UNDERTAKER: T. Lennartz
ADDRESS: Montrose

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.

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

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and S

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from
.....,19....., to ....
that I last saw h..... alive on....., 19..
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....

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).....

, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF
20. UNDERTAKER	ADDRESS