

ESD APR 24 1939

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

12580
Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan 2 Registration District No. 849
 (b) Township Union 1 Primary Registration District No. 6115 Registered No. 1
 (c) City..... (d) Street No..... (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

15 Dora Eliza Evans
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Evans
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 15-1868
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 7 2
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 17 1939
 22. I HEREBY CERTIFY, That I attended deceased from Aug 1936, to Mar 17 1939
 I last saw her... alive on Aug 1936 Death is said to have occurred on the date stated above, at 6 A m.
 The principal cause of death and related causes of importance were as follows:

Chronic Valvular Disease of heart
 Date of onset
 Other contributory causes of importance: g. 2. u

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y. 1
 FATHER 13. NAME Augustus Richmond
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y. 1
 MOTHER 15. MAIDEN NAME Weaver
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y.

17. INFORMANT (ADDRESS) Aubrey Evans Green Castle Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Ewing Cem DATE 3-19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Glen E Kent & Son Green City Mo
 20. FILED 3-31 1939 Virginia Gibson Local Registrar.

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....
 24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify 771 (Signed) M. Herington, M.D., M. D.
 (Address) Green City Mo

WRITE PEANUT, 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.

1 X14023

RECEIVED

District Health Officer No. 10

District File Number 10-34-760

Date Filed APR 19 1939

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

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.