

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

19088

Do not use this space.

1. PLACE OF DEATH

(a) County Key Madrid 2 Registration District No. 274
 (b) Township Key Madrid Primary Registration District No. 6261
 (c) City Lilbourn (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

Registered No. _____

2. PRINT FULL NAME

(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 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) 1-29-40

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. travel
 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 _____

12. BIRTHPLACE (CITY OR TOWN) Lilbourn mo. (STATE OR COUNTRY)

FATHER 13. NAME Merrel Evans

14. BIRTHPLACE (CITY OR TOWN) Steele mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Albina Brunner

16. BIRTHPLACE (CITY OR TOWN) Lilbourn mo. (STATE OR COUNTRY)

17. INFORMANT Merrel Evans (ADDRESS) Lilbourn mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE inwards DATE 3-4-1940

19. FUNERAL DIRECTOR Hill Bros. (ADDRESS) Lilbourn mo.

20. FILED 3-4-1940 E. E. Jones Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-3-1940

22. I HEREBY CERTIFY, That I attended deceased from 1-31-1940, to 3-3-1940

I last saw him alive on 3-3-1940. Death is said to have occurred on the date stated above, at 5:30 P.m.

The principal cause of death and related causes of importance were as follows:

Malnutrition

Date of onset 12/27

Other contributory causes of importance: _____

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? no

If so, specify _____ (Signed) G. N. Wilson M. D.

57 (Address) Lilbourn 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.

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158

RECEIVED

District Health Officer No. 2,

District File Number 640 - 8A2

Date Filed 6/10/40

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19088

Registration District No. 274

Primary Registration District No. 6261

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Lewis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Alfred E Evans

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Years	Months	Days	If less than one day
	<u>1</u>	<u>4</u>	hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 3 year 1950 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death malnutrition

Due to Can not state cause of malnutrition

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 158

Major findings: _____ Of operations _____ Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature E. N. Wilson (M. D. or other) _____

Address Ballou Date signed _____

SUPPLEMENTAL

S-19088