

FILED FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3346

Registration District No. 534

Primary Registration District No. 4319

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Mason

(b) City or town New Cambria
(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 75 yr years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Mason ⁶¹

(c) City or town New Cambria MO
(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.? 87 0 years.

3. (a) PRINT FULL NAME Hannah Evans

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 16th day January
year 1941 hour 6 minute 20 A.M.

4. Sex Female 5. Color or race white

6. (a) Single widowed, married, divorced widowed

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

7. Birth date of deceased 04 15 1852
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 5th 1941 to Jan 16th 1941; that I last saw her alive on Jan 16th 1941; and that death occurred on the date and hour stated above.

8. AGE: Years 88 89 Months 3 Days 1 If less than one day _____ hr. _____ min.

Immediate cause of death Lobar Pneumonia Duration 3 Day

Due to Influenza 8 Day

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

Due to _____

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

10. Usual occupation Retired Housekeeper

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy no

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name John Reese 4

13. Birthplace Wales 4
(City, town, or county) (State or foreign country)

14. Maiden name Mary Williams

15. Birthplace Wales 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ester East

(b) Address New Cambria MO

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation new Cambria MO

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

18. (a) Signature of funeral director H. G. Schwartz

(b) Address Burial MO

19. (a) Feb 8-1941 (b) D. West
(Date received local registrar) (Registrar's signature)

23. Signature D. West (M. D. or other) D

Address New Cambria MO Date signed Jan 17, 1941

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

MOTHER FATHER

EX I
V. J. BERNYIAEAL RECORD

SEP 22 1944

RECEIVED

District Health Officer No. 10

District File Number 2-41-279

Date Filed FEB 13 1941

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.....

J. J. Edwards

....., Registered Apprentice No.....

working under my personal supervision.

Signed *J. J. Edwards*

Licensed Embalmer No. 1961

P. O. Address Devies, Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3346

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 534

Primary Registration District No. 4319

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Madison
(b) City or town New Cambria
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Hannah Evans

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

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

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

7. Birth date of deceased Oct 15 - 1832
(Month) (Day) (Year)

8. AGE: Years 88 Months 3 Days 1 If less than one day _____ 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) Feb 9 - 1941 (b) [Signature]
(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 Jan day 16
year _____ 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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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) _____ Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address New Cambria Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

