

STANDARD CERTIFICATE OF DEATH

Registration District No. **247** Primary Registration District No. **5323** Registrar's No. **2**

1. PLACE OF DEATH:
 (a) County **Dallas**
 (b) City or town **Rural Wilson**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Long Lane Mo
(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 **Joe Green 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 **M**
 6. (b) Name of husband or wife **Martha Evans**
alive _____ years
 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased **Aug. 23-1868**
(Month) (Day) (Year)
 8. AGE: Years **72** - Months **6** Days **17**
If less than one day hr. _____ min.

9. Birthplace **Dallas Co. Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Mark Evans**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Claud Burtis**
 (b) Address **Long Lane Mo**

17. (a) **Burial** (b) Date thereof **3-12-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Flat Woods**

18. (a) Signature of funeral director **L.B. Jones**
 (b) Address **Buffalo Mo.**

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Dallas Co**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Long Lane Mo.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **11**
 year **1941** hour **2** minute **A** M.
 21. I hereby certify that I attended the deceased from **3-1-41**
 _____, 19____, to **3-11-41**, 19____
 that I last saw him alive on **3-10-41**, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**
arterio sclerosis & hypertension
 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?
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(Specify type of place) _____
 While at work _____ (e) Means of injury _____
 23. Signature **W. H. Plummer** (M. D. or other) _____
 Address **Buffalo Mo.** Date signed **3-29-41**

Duration

10d

OK

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 7,

District File Number 5-41-886

Date Filed 5-19-41

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 Clyde Montgomery
Licensed Embalmer No. 3592
P. O. Address Buffalo, 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. 14381
Registrar's No. 2

Registration District No. 247

Primary Registration District No. 5343

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Wilson T.P.
(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 Joe Green 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 m
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 17
If less than one day _____ hr _____ min

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 31 1971 (b) L. R. Talbot
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 11
year 1971 hour _____ minute _____ M.

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

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 G. C. Plummer (M. D. or other) _____

Address Buffalo Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

S-14381