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K23159

FILED JUN 10 1941

STANDARD CERTIFICATE OF DEATH

19698

State File No.

17491

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 144

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution: State Hospital No. #1
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 3/9 am 6 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME LIZZIE EVANS

3. (b) If veteran, name war

3. (c) Social Security No. D.K.

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 D.K.
(Month) (Day) (Year)

8. AGE: Years 65 (2) Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business

12. Name D.K.

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

14. Maiden name D.K.

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

16. (a) Informant Hospital Records

(b) Address

17. (a) Removal (b) Date thereof 5-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia mo

18. (a) Signature of funeral director G. O. Roberts

(b) Address Columbia mo

19. (a) May 16, 1941 (b) R. N. Crews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County CAMDEN

(c) City or town CAMDEN TOW
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 10
year 1941 hour 8 minute 22 P. M.

21. I hereby certify that I attended the deceased from Feb 4, 1941, to MAY 10, 1941;
that I last saw h. ea alive on MAY 10, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL Hemorrhage

Due to Arteriosclerosis

Due to 4/2/41

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

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? NO

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Katherine Shiley (M. D. or other) D.M.R.

Address State Hospital #1 Date signed 5-10-41

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.