. No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24312

District No. 399 Primary Registration District No. 1002 Registrar's No. 2851

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days 0 (Specify whether years, months or days)
In this community: unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 048
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3503½ E. 27th St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: John Evans
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Sadie Graves Evans
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: Jan (Month) 15 (Day), 1866 (Year)
8. AGE: Years 75 Months 6 Days 13 If less than one day ___ hr. ___ min.
9. Birthplace: (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: unknown
13. Birthplace: unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Harry Feisinger
(b) Address: 3503½ E. 27th
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation: Weston Mo.
18. (a) Signature of funeral director: Stine & McClure
(b) Address: 3235 Holmes Blvd. K.C. Mo.
19. (a) 7-29-41 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28th year 1941 hour 9 minute 15 P. M.
21. I hereby certify that I attended the deceased from 7-10-41, 19__, to 7-28-41, 19__; that I last saw him alive on 7-28-41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia;	
Arteriosclerotic heart disease;	
Thrombosis of anterior tibial artery left	
Due to with amputation of left leg, proximal thigh	
Due to Arteriosclerosis, senile	
Other conditions (Include pregnancy within 3 months of death) A.F.I.	

Major findings:
Of operations: 4 of 4
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Henry R. Shaw (M. D. or other) D
Address: Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Felix Rey

Licensed Embalmer No. H/127

P. O. Address 3235 [illegible]

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24312

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2851

1. PLACE OF DEATH:

(a) County
(b) City or town
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME John 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 Wd

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 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) (Burial, cremation, or removal) (b) Date thereof 7-24-41 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9/11/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from 19 to 19; that I 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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY