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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 28 1943

Registration District No.

Primary Registration District No. 2053

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rolla

(c) Name of hospital or institution: McFarland Hospital

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

In this community..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town 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 Thomas Clinton Evans

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lucy Isabelle Evans 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased 6 18 1888 (Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>54</u> | <u>7</u> | <u>12</u> |hr.min. |

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

10. Usual occupation Farmer

11. Industry or business.....

MOTHER FATHER

12. Name James R. Evans

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

14. Maiden name Rebecca Doyle (State or foreign country)

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

16. (a) Informant Mrs. Clinton Evans (b) Address Dixon, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ 1/ 43 (Month) (Day) (Year) (c) Place: burial or cremation Kenner Cemetery

18. (a) Signature of funeral director Fred H. Gilbert (b) Address Dixon, Missouri

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30 year 1943 hour 8 minute 45 P.M. January 4

21. I hereby certify that I attended the deceased from 28 19..... to Jan. 30 19 43 that I last saw him alive on Jan. 30 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death.....

General peritonitis following a strangulated umbilical hernia.

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

Major findings: 122a!

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?

23. Signature William M. Starvo (Specify type of place) (M. D. or other) (Date signed)

While at work..... Means of injury.....

Address.....

1092 (Licensed Embalmer's Statement on Reverse Side)

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.....

January 30, 1943

working under my personal supervision.

Registered Apprentice No.....

Signed.....

Fred W. Gilbert

Licensed Embalmer No. **2341**

P. O. Address..... **Dixon, Missouri**

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. 7242
Registrar's No. 16

Registration District No. 275

Primary Registration District No. 3053

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Reella
(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 Thomas Clinton Ewan

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 _____ years

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

8. AGE: Years 54 Months 9 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-7-1943 (Date received local registrar) (b) Kella Walker (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 _____ Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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) (e) Means of injury _____

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

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

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