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DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED JUN 19 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21101

State File No. _____

Registration District No. 312

Primary Registration District No. 6056

Registrar's No. 8

1. PLACE OF DEATH:

(a) County St. Clair Butler Township

(b) City or town Lowry City *Boonville* Missouri
(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 6 weeks
(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 Gentry *38*

(c) City or town Albany
(If outside city or town limits, write "RURAL") *1*

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

(e) Citizen of foreign country? No *1* (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas H. Evans

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 500-4-7768

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1945 hour 4 minute 30P 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.

4. Sex Male 5. Color or race White

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

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased October 29 1884
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis *Duration*
Had been bothered with heart attacks for several years.

Due to _____

Due to _____

8. AGE: Years 60 Months 7 Days 7
If less than one day _____ hr. _____ min.

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

Major findings: NONE

Of operations _____

Of autopsy NONE

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

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name William B. Evans

13. Birthplace Not known *4*
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known *4*
(City, town, or county) (State or foreign country)

16. (a) Informant Gladye M. Evans

(b) Address Lowry City Missouri

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? _____

17. (a) Burial *1* (b) Date thereof 6-8-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Osceola Funeral Home

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director Osceola Missouri

(b) Address _____

19. (a) 6-7-45 (b) V. E. Robt. Harrison
(Date received local registrar) (Registrar's signature)

23. Signature Direct Blooded *3* (M: D. or other)
Address Osceola Mo Date signed 6/7/45

1129

Lawmer

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

REC'D
Discharge No. 7
5-45-59
6-15-40
MAY 25 1959

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 *J. B. Goodrich*

Licensed Embalmer No. 3038

P. O. Address *Psicote Md*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *July*Registrar's No. *8*Registration District No. *312*Primary Registration District No. *6056*

1. PLACE OF DEATH:

- (a) County *St. Clair*
 (b) City or town *Louisy City, Butler Miss*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: *Rusali*
 (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)

3. (a) PRINT
FULL NAME*Thomas H. 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 _____ years

7. Birth date of deceased
- Oct 29*

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

60

hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) *MO*

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) _____ (b) _____

(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 _____ Day _____
-
- year
- 1945*
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
-
- to _____, 19____;
-
- that I last saw him/her 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 statisti-
cally.

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 _____

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

SUPPLEMENTARY

21101