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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26401
3404

State File No.
Registrar's No.

FILED SEP 1949
Registration District No. 149

Primary Registration District No. 1002

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: MENORATH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 1/2 WEEKS
(Specify whether years, months or days) 3 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 3711 HOGANES STREET
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MISS MILDRED ELIZABETH EVANS
(b) If veteran, name war. NO
(c) Social Security No. 494-20-8729

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month AUG day 13 year 1945 hour 2 minute 00 A.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.

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (c) Age of husband or wife if alive... years
7. Birth date of deceased JANUARY 1 1925
(Month) (Day) (Year)

Immediate cause of death
Due to Staphylococcus infection
Duration
Other conditions (Include pregnancy within 3 months of death)

8. AGE: Years 20 Months 7 Days 12 hr. min.

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

10. Usual occupation RECEPTIONIST

11. Industry or business K.C. DENTAL COLLEGE

12. Name WILLIAM T. EVANS

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

14. Maiden name DORA KESTERSON

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

16. (a) Informant Mrs. Dora Evans

(b) Address Kingsville, Missouri

17. (a) Burial (b) Date thereof Aug 16 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HOB DEN, MISSOURI

18. (a) Signature of funeral director D. H. ...
(b) Address 1401 Brush Creek Blvd

19. (a) 8-14-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

Due to Staphylococcus infection
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy no History & Inspection
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 3
23. Signature Jennie Walker (M. D. or other) 3
Address 1924 ... Date signed 8-13-45

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 *K C Newcomer Jr*

Licensed Embalmer No. *4043*

P. O. Address *K C Mrs*

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.

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Memorial Hosp.
(d) Length of stay: In hospital or institution 6 1/2 weeks
In this community 6 1/2 weeks
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(d) Street No.
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME Mildred Elizabeth Evans
3. (b) If veteran, name war 3. (c) Social Security No.

20. DATE OF DEATH: Month Aug. day 13
year 1945 hour minute M.

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

21. I hereby certify that I attended the deceased from Coroner 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 Peritonitis

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

Due to staphylococcus infection (n.m.o.)
Due to
Other conditions: (Include pregnancy within 3 months of death)
Major findings: 24a
Of operations
Of autopsy no history & inspection

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

10. Usual occupation
11. Industry or 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)

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) (e) Means of injury.

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)
(c) Place: burial or cremation

23. Signature James C. Walker (M. D. or other)
Address 1142 48th St. Bldg. Date signed 8-13-45

18. (a) Signature of funeral director
(b) Address
19. (a) 8-14-45 Steraldine Holmes
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

1011

26401