

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 2 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

218

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Biggsville
(b) City or town St. Joseph
(c) Name of hospital or institution: State Hospital No. 2
(d) Length of stay: In hospital or institution 5 yrs. 7 Mo. 30 days
In this community 6 yrs. 1 Mo. 30 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Jane W. Everhart

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive years
7. Birth date of deceased March 5 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 10 4 hr. min.

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

10. Usual occupation Baker

11. Industry or business Bakery Queen

MOTHER FATHER { 12. Name Samuel Everhart
13. Birthplace Ohio
14. Maiden name Bell (Last Name Unknown)
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Harp. Recard
(b) Address State Hosp. No. 2 St. Joseph Mo
17. (a) Buried (b) Date thereof 1-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Kirkville Mo
18. (a) Signature of funeral director or undertaker Walter H. Hershberger
(b) Address W. H. Hershberger
19. (a) 1-21-47 (b) W. B. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirkville
(d) Street No. 609 So. Main St.
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1947 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 1, 1946, to Jan 9, 1947;
that I last saw him alive on January 9, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cirrhosis of Liver
Due to Unknown

Other conditions Bilateral Inguinal Hernia
(Include pregnancy within 3 months of death)

Major findings: Of operations 122
Of autopsy Cirrhosis of Liver
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature James W. Forman (M. D. or other)
Address State Hosp. No. 2 St. Joseph Mo Date signed 10-1-47

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.....

Albert E. Harrington

Licensed Embalmer No. *3258 Mrs.*

P. O. Address. *St. Joseph, Mo.*

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.