

FILED SEP 15 1947

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 1075

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Knoski Nursing Home, 1401 Jules
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 1/2 Yrs. (Specify whether
In this community Thirty Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Buchanan.
(c) City or town St. Joseph.
(If outside city or town limits, write "RURAL")
(d) Street No. 1401 Jule Street-
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EDWARD T. EVENSON.

3. (b) If veteran, name war No. 3. (c) Social Security No. None.

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 12th. 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 8 22 -- hr. --- min.

9. Birthplace Murray County, Minnesota.
(City, town, or county) (State or foreign country)

10. Usual occupation Cabinet Maker.

11. Industry or business Retired.

MOTHER FATHER

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Welfare Boards Records.

(b) Address Patee Hall- St. Joseph, Mo.

17. (a) Burial (b) Date thereof 9/6/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery.

18. (a) Signature of funeral director Wm E. R. Sidenfaden

(b) Address 602 South 10th Street

19. (a) 9-8-47 (b) W. B. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day third
year 1947 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from 8-15-47
_____, 19____, to 9-3-47, 19____.
that I last saw him live on 9/2, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 6 days

Due to chronic hypertension 5 yrs
Due to chronic myocarditis 1 yr

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

Major findings: 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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Wm E. R. Sidenfaden (Date signed 9/24/47)
Address St. Joseph, Mo.

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 *Mollie E. Sidenfaden Fox*

Licensed Embalmer No. *4235*

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.