No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 28 1948
Registration District No. 227

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27091
Primary Registration District No. 5804
Registrar's No. 46

1. PLACE OF DEATH:
(a) County Monroe
(b) City or town Rural - Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Monroe Co. Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 MO. (Specify whether
In this community 75 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Monroe 69
(c) City or town Paris 2
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME WILLIAM EVANS
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE
4. Sex MALE 2
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced WIDOWED 1
6. (b) Name of husband or wife LAURA THORNTON
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased OCT. (Month) 20 (Day) 1948 (Year)

8. AGE: Years 81 | Months 9 | Days 22 | If less than one day — hr. — min.

9. Birthplace Unknown (City, town, or county) KY. (State or foreign country) 1
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name Unknown 9
13. Birthplace " (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name " 9
15. Birthplace " (City, town, or county) (State or foreign country)
16. (a) Informant Co. Infirmary Records
(b) Address Paris, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-48 (Month) (Day) (Year)
(c) Place: burial or cremation Walnut Grove
18. (a) Signature of funeral director Speed & Blakey
(b) Address Paris, Mo.
19. (a) 8-13-48 (Date received local registrar) (b) Elbert Baker (Registrar's signature) 205

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 12
year 1948 hour 9 minute P.M.
21. I hereby certify that I attended the deceased from April 2, 1948 to Aug 12, 1948
that I last saw him alive on Aug 12, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	1 Day
Due to Arterio-Sclerosis	Nil
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 83	
Of autopsy	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other) M.D.
Address Paris, Mo. Date signed 8-13-48

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

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-48-160
Date Filed AUG 26 1948

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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.

No. 2B
M—3-45
P-X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. ____ Primary Registration District No. 5804 Registrar's No. 46

1. PLACE OF DEATH:
(a) County Monroe
(b) City or town ____ (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 years, months or days) In this community ____

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 ____

3. (a) PRINT FULL NAME William Evans
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Male
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)
8. AGE: Years ____ Months ____ Days ____ If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)

MOTHER
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) ____ (Date received local registrar) (b) Elbert Baker M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 12 Year 1948 Hour ____ Minute ____ 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.

	Duration
Immediate cause of death ____	
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 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

205

1948
S-27091