

NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36598

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4097 Registrar's No. 180

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Cass	
b. CITY (If outside corporate limits, write RURAL and give name of town) Harrisonville		c. LENGTH OF STAY (in this place) 2 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital		e. STREET ADDRESS (If rural, give location) Rural W. Dotan 4 mi S.W. of Westline	

3. NAME OF DECEASED (Type or Print) Franklin S. Evans	4. DATE OF DEATH (Month) (Day) (Year) Nov. 16-49
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5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED 2	8. DATE OF BIRTH Oct. 12-1862	9. AGE (In years) (Month) (Day) (Year) 87 1 7
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Farmer, 11 yrs. retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY USA.
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13a. FATHER'S NAME Henry C. Evans	13b. MOTHER'S MAIDEN NAME Nancy	13c. NAME OF HUSBAND OR WIFE Emma C. Moul.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Henry Evans	17. ADDRESS Westline
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Nephritis DUE TO (c) Scurvy		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **10-1-1947**, to **11-16-1949**, that I last saw the deceased alive on **11-15-1949**, and that death occurred at **3:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE S. S. Jones	23b. ADDRESS Harrisonville Mo	23c. DATE SIGNED 11-17-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 18-49	24c. NAME OF CEMETERY OR CREMATORY Brady Ken	24d. LOCATION (City, town, or county) (State) Cass, Co., Mo
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DATE REC'D BY LOCAL REG. Nov. 17, 1949	REGISTRAR'S SIGNATURE Laura J. Jones	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W. H. Jones Harrisonville Mo
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(Revised Embalmer's Statement on Reverse Side)

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

19
6
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Wm. A. Johnson* _____

Licensed Embalmer No. *3920*

P. O. Address *Harrisonville*

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.