

STANDARD CERTIFICATE OF DEATH

State File No. **1850**

FILED **JAN 28 1954**

BIRTH NO. _____ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **3033** Registrar's No. **12**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY Laclede		a. STATE Missouri b. COUNTY Laclede	
b. CITY OR TOWN Lebanon		c. CITY OR TOWN Lebanon	
c. LENGTH OF STAY (in this place) 2 yrs		d. STREET ADDRESS Long's Rest Home	
d. FULL NAME OF HOSPITAL OR INSTITUTION Long's Rest Home		(If rural, give location) 0	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) Jackson b. (Middle) Jones c. (Last) Evans			(Month) (Day) (Year) Jan. 16, 1954		
5. SEX M		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED widowed	
8. DATE OF BIRTH April 29 1861		9. AGE 92		10. UNDER 18 8 17	
10a. USUAL OCCUPATION Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE Camden Co. Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13. FATHER'S NAME Gingham Evans		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Cynthia Evans	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Viola Beavers	
(Yes, no, or unknown) (If yes, give war or dates of service)				ADDRESS Lebanon Mo.	

18. CAUSE OF DEATH		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Bronchial Pneumonia		5 days	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		DUE TO (b) _____			
		DUE TO (c) _____			
		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"/>	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-11, 1954, to 1-16, 1954, that I last saw the deceased alive on 1-16, 1954, and that death occurred at T. A. m., from the causes and on the date stated above.

23a. SIGNATURE R. E. Harell M.D.		23b. ADDRESS Lebanon, Mo.		23c. DATE SIGNED 1-16-54	
(Degree or title)					

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/17/54		24c. NAME OF CEMETERY OR CREMATORY City Cemetery	
				24d. LOCATION (City, town, or county) (State) Lebanon, Mo.	

DATE REC'D BY LOCAL REG. 1-20-1954		REGISTRAR'S SIGNATURE Hella L. Gray		25. FUNERAL DIRECTOR'S SIGNATURE W. E. Holman	
				ADDRESS Lebanon, Mo.	

(Licensed Embalmers' Statement on Reverse Side)

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

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Received JAN 23 1954
Sable County Health Uni
File No. 1-54-15
Date filed JAN 27 1954

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.