

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001281

STATE FILE NUMBER

216

JAN 28 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300
-57

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hosp. | | Length of stay in lb 50 yrs. | d. STREET ADDRESS 211 E. Linwood |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Michael E. Evans | | | 4. DATE OF DEATH Month Day Year 1 - 11 - 1959 | |
|--|--|--|---|--|

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|-------------|------------------------|---|--------------------------------|------------------------------------|----------------------------------|------------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12, 1883 | 9. AGE (In years last birthday) 75 | 10. FUNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
|-------------|------------------------|---|--------------------------------|------------------------------------|----------------------------------|------------------------------------|

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|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Road Conductor | 10b. KIND OF BUSINESS OR INDUSTRY Union Pacific | 11. BIRTHPLACE (City and state or country) Manhattan, Kansas | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|--|---|--|

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|---------------------------------------|--|--|
| 13a. FATHER'S NAME (Unknown) Evans | 13b. MOTHER'S MAIDEN NAME (Unknown) O'Neill | 14. NAME OF HUSBAND OR WIFE Florence H. Evans |
|---------------------------------------|--|--|

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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 None | 16. SOCIAL SECURITY NO. 490-16-0797A | 17. INFORMANT Edward F. Evans | Address 211 E. Linwood K.C. Mo. |
|---|---|----------------------------------|------------------------------------|

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|--|-----------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Bronchopneumonia | |
| | DUE TO (c) Carcinomatosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | |

| | | | | |
|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from 3/29/58 to 1/11/59 and last saw ^{her} alive on 1/10/59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | | |
|-----------------------------------|---------------------------|---------------------------------|-----------------------------|
| 22a. SIGNATURE Joseph M. Yasso | (Degree or title) D.O. | 22b. ADDRESS 679 Walnut K.C. | 22c. DATE SIGNED 1/14/59 |
|-----------------------------------|---------------------------|---------------------------------|-----------------------------|

| | | | |
|--|--------------------------|--|--|
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | 23b. DATE 1-14 - 1959 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) Kansas City, Missouri |
|--|--------------------------|--|--|

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|---|--------------------------------------|---|---|
| 24. FUNERAL DIRECTOR Melody-McGilley-Eylar | ADDRESS 20 W. Linwood K.C. Mo. | 25. DATE RECD. BY LOCAL REG. 1-13-59 | 26. REGISTRAR'S SIGNATURE Irene Marshall |
|---|--------------------------------------|---|---|

K.C. Mo. Licensed Embalmer's Statement on Reverse Side

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Joseph M. Yasso

All diseases in Part I must be causally related.

Dr. S. J. ...
Academy Building
BA 1-7955
about 4 P.M.

812

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
Signature of Student Embalmer

Signed *John H. Pryor*

Licensed Embalmer No. 2999

P. O. Address... K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.