

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036156**

**FILED VS. NOV 2 1959**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5057

STATE FILE NUMBER

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b _____		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2601 Agnes Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2601 Agnes Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>(Jennie) VIRGINIA EVANS</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>October 18th 1959</b>					
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1 17 1887</b>		<b>9. AGE (last birthday)</b> <b>72 yrs</b>	
IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>home</b>	
<b>11. BIRTHPLACE</b> (City and state or country) <b>Centerview Mo.</b>				<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>					
<b>13a. FATHER'S NAME</b> <b>Arthur Schrawyer</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Amanda Graham</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Olie Evans (deceased)</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>none</b>			<b>17. INFORMANT</b> Address <b>Robert Schrawyer 2000 Montgall Ave.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b>								INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardio Vascular Disease</b>								<b>indefinite</b>	
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY		STATE	
<b>21. I attended the deceased from</b> <u>October 16, 1959</u> <b>and last saw her</b> <u>October 18, 1959</u> <b>alive on</b> <u>10/18/59</u> Death occurred at <u>1:45 P</u> <b>m</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
<b>22a. SIGNATURE</b> (Degree or title) <i>George H. Taft M.D.</i>				<b>22b. ADDRESS</b> <b>2204 E. 18th Street</b>				<b>22c. DATE SIGNED</b> <b>10/20/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE</b> <b>10 22 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lincoln Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Kansas City, Mo.</b>		(State)	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Adkins Funeral Home Kansas City, Mo.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>10 21 59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Alva Minshall</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
George H. Taft

**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 *James H. Taylor*

Licensed Embalmer No. 4412

P. O. Address Home City

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.