

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 7 1959

59-039753

STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. _____ Registrar's No. 198

1. PLACE OF DEATH a. COUNTY <u>GRUNDY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MERCER</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>TRENTON TWP</u>		Length of stay in 1b <u>9 MO</u>		c. CITY OR TOWN <u>MILL GROVE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PLAINVIEW REST HOME</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>WASHINGTON TOWNSHIP</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH MARGARET EVANS</u>				4. DATE OF DEATH Month Day Year <u>NOV 25 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		
13a. FATHER'S NAME <u>NELSON J. NICHOLS</u>			13b. MOTHER'S MAIDEN NAME <u>CORNELIA WALDRON</u>			14. NAME OF HUSBAND OR WIFE <u>HERBERT EVANS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MARGARET OWEN MILL GROVE MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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							INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>2-17-59</u> to <u>11-25-59</u> and last saw her ^{her} _{him} alive on <u>11-25-59</u> Death occurred at <u>8:05 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Mason</u> <u>MD</u>				22b. ADDRESS <u>Trenton MO</u>		22c. DATE SIGNED <u>11-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV-28-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>		23d. LOCATION (City, town, or county) <u>SPICKARD MO</u>		(State)	
24. FUNERAL DIRECTOR <u>SCHOOLER FUNERAL HOME</u>			ADDRESS <u>SPICKARD MO.</u>		25. DATE RECD. BY LOCAL REG. <u>11-28-59</u>	26. REGISTRAR'S SIGNATURE <u>June Fair</u>	

ENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 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.