

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**

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

**59-040923**

STATE FILE NUMBER

RECEIVED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 183

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>MACON</u>		a. STATE <u>MISSOURI</u>		b. COUNTY <u>SHEBBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u>		Length of stay in 1b <u>4 MONTHS</u>		c. CITY OR TOWN <u>SHEBBYVILLE, MO.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>SHEBBYVILLE, R.F.D.</u>	
				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year			
<u>EMMA JAYNE EVANS</u>			<u>Oct 11, 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>FEB 14, 1928</u>	9. AGE (last birthday) <u>81</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>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>	11. BIRTHPLACE (City and state or country) <u>SHEBBYVILLE, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>SAMUEL ABHISON</u>	13b. MOTHER'S MAIDEN NAME <u>FRANCES MILLER</u>	14. NAME OF HUSBAND OR WIFE <u>EDGAR R. 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. <u>NONE</u>	17. INFORMANT Address <u>EDNA MAY ARNOOLD, MACON</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u>		<u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Coronary Heart Disease</u>		<u>2 years</u>
DUE TO (c) <u>Senile Debility</u>		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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>Oct 1957</u> to <u>Oct 11, 1959</u> and last saw her <sup>her</sup> alive on <u>Oct 11, 1959</u> . Death occurred at <u>6:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Paul M. Meeley</u>	22b. ADDRESS <u>MACON, MISSOURI</u>	22c. DATE SIGNED <u>10/15/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Oct 13, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. CEMETERY SHEBBYVILLE MISSOURI</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS <u>GREENING - SHEBBYVILLE, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11/2/59</u>	26. REGISTRAR'S SIGNATURE <u>Paul M. Meeley</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Charles V. Greening

Licensed Embalmer No. 46250

P. O. Address Clarence

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.