

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

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FILED VS DEC 17 1959 14

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 4459 Registrar's No. 60

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Clair</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u> Length of stay in 1b _____ c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Med; Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u> c. CITY OR TOWN <u>Collins</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>7th West Collins</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>John Michael Evans</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Dec; 6, 1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/14/58</u>	<b>9. AGE (last birthday)</b> <u>1</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Collins Missouri</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>Emmett Evans</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Josephine Gooding</u>		<b>14. NAME OF HUSBAND OR WIFE</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Emmett Evans, Collins Missouri</u>	
<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) <u>Suffocation</u> DUE TO (b) <u>Grain of Pop Corn Lodged in Trachea</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</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 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 checked="" 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.) <u>Grain of Pop Corn Lodged in Trachea</u>				
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year <u>8:00 A 12/6/59</u>		<b>20d. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>In Home</u>				
<b>20e. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>Collins (7th W) St. Clair Mo;</u>						
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at <u>about 7:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>Ruth Seewers, L.R.</u>			<b>22b. ADDRESS</b> <u>Osceola Missouri</u>		<b>22c. DATE SIGNED</b> <u>12/7/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>12/8/59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holsapple</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Collins Missouri</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Goodrich Funeral Home, Osceola Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-10-1959</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Ruth Seewers</u>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *J.B. [Signature]*

Licensed Embalmer No. 3038

P. O. Address *Osceola, 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.