SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-013134
STATE FILE NUMBER

Registration District No. 88 Primary Registration District No. 5330 Registrar's No. 8

AMENDED

FILED APR 17 1961

1. PLACE OF DEATH
a. COUNTY CRAWFORD
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN OSAGE TWP. Length of stay in 1b 12 YRS.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3 Mi. So-DILLARD, Mo. Inside Limits Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY CRAWFORD
c. CITY OR TOWN OSAGE TWP. Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) 3 Mi. So.-DILLARD, Mo. Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN TILLISON EVANS

4. DATE OF DEATH Month Day Year APRIL-9-1961

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH 7-15-71
9. AGE (last birthday) 89 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) FARMER
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) OTTAWA-KANSAS.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME SAMUEL EVANS
13b. MOTHER'S MAIDEN NAME CHRISTINA BEBORN
14. NAME OF HUSBAND OR WIFE FLORENCE EVANS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address GEO. GIBBS-DILLARD, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senile debility — INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 _____, to 4/5/61 and last saw ~~her~~ him alive on 4/5/61
Death occurred at 9:00 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) DO
22b. ADDRESS Steelville Mo
22c. DATE SIGNED 4/11/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 4-11-1961
23c. NAME OF CEMETERY OR CREMATORY EATON CEMETERY
23d. LOCATION (City, town, or county) (State) CRAWFORD COUNTY, Mo.

24. FUNERAL DIRECTOR ADDRESS Thomas S. Halbert - STEELVILLE, Mo.
25. DATE RECD. BY LOCAL REG. 4-11-61
26. REGISTRAR'S SIGNATURE Mrs. Hazel Lichius

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
SHOULD READ
ITEM NO.
BY AFFIDAVIT OF
MEDICAL CERTIFICATION

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_____ Signed Thomas S. Halbert

Signature of Student Embalmer

Licensed Embalmer No. 4332

P. O. Address STEELVILLE,

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.