SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-037654
STATE FILE NUMBER

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 187

FILED OCT 30 1961

1. PLACE OF DEATH
a. COUNTY LIVINGSTON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE — Length of stay in 1b: 6 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1418 POLK ST. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY LIVINGSTON
c. CITY OR TOWN CHILLICOTHE — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1418 POLK ST. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MORGAN Middle IVOR Last EVANS
4. DATE OF DEATH: Month OCTOBER Day 14 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/20/1901
9. AGE (last birthday): 59
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): Retired Salesman
10b. KIND OF BUSINESS OR INDUSTRY: AUTOMOBILE
11. BIRTHPLACE (City and state or country): DAWN, MISSOURI
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: THOMAS J. EVANS
13b. MOTHER'S MAIDEN NAME: MARGARET JAMES
14. NAME OF HUSBAND OR WIFE: LYDIA EVANS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
17. INFORMANT: Mr. TOM EVANS: Address MARSHALL, MISSOURI

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Auricular & Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Few Minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterial Sclerosis — 2 yrs
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Emphysema & Kyphosis
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 Feb 2-57, to Oct 14-61 and last saw ~~her~~ him alive on Oct 14-57
Death occurred at 5:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Joseph A. Conrad (Degree or title) M.D
22b. ADDRESS: Chillicothe Mo
22c. DATE SIGNED: Oct 17-61
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10/16/61
23c. NAME OF CEMETERY OR CREMATORY: RESTHAVEN CEMETERY
23d. LOCATION (City, town, or county) (State): CHILLICOTHE, MISSOURI
24. FUNERAL DIRECTOR: NORMAN FUNERAL HOME: ADDRESS CHILLICOTHE, MO.
25. DATE RECD. BY LOCAL REG.: Oct 16, 1961
26. REGISTRAR'S SIGNATURE: Amalee Taylor

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 4 1962

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 John P. Lodges

Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MIS

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.