

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

26968
 3581

1. PLACE OF DEATH

County Jackson
 Township Raw
 City Kansas City, Mo. (No. Wesley Hospital)

Registration District No. 1000
 Primary Registration District No. 1000

File No. 26968-3581
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Faust E. Evans

(a) Residence. No. 2936 Benton Blvd St., 11 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs A.M. Evans

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/8/1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 5 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Druggist
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Canada

10. NAME OF FATHER W. A. B. Evans

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Canada

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Canada

14. INFORMANT Mrs A.M. Evans

(Address) Somerset Hotel

15. FILED 8/30 W. W. Crawford REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 30 1930

I HEREBY CERTIFY, That I attended deceased from July 12 1930, to Aug. 29 1930 that I last saw h. alive on 19 and that death occurred, on the date stated above, at 11 A. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Mitral Regurgitation

92A (duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY)

Chorea (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) F. G. Lindsay M. D.

Aug. 30 1930 (Address) 832 Upple Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Omaha Neb.

Aug. 31 1930

20. UNDERTAKER

ADDRESS

W. W. Newcomb's Sons A.C. Mo.

159. J. N. Lindley
S. P. C. 1847
S. P. C. 1847
S. P. C. 1847

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 25-81
 City X. City (No.) St. Ward)

2. FULL NAME

Frank E. Evans

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-8-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 3 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 8/31 19 30 M. M. Corwin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 30 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19....., and that I last saw him and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-26968