

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1405  
Registrar's No. 390

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Jackson City  
(c) Name of hospital or institution:  
2010 East 43rd Street  
(d) Length of stay: In hospital or institution 1 Month  
In this community 1 Month

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County Leavenworth  
(c) City or town Linwood  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mrs. Ruth Eliza Evans  
(b) If veteran, name war None  
(c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife Mr. Francis M. Evans  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 9 1884

8. AGE: Years 95 Months 8 Days 16  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Perry County Ohio

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_  
12. Name Nathan Rose  
13. Birthplace Ohio  
14. Maiden name Eliza Ann Hall  
15. Birthplace Ohio

16. (a) Informant's own signature R. A. Evans  
(b) Address Linwood, Kan.

17. (a) Burial (b) Date thereof Jan. 28, 1940  
(c) Place: burial or cremation Fulton, Kansas

18. (a) Signature of funeral director O. W. Deaconis  
(b) Address 1401 Brush Creek Blvd.  
19. (a) Jan. 22, 1940 (b) M. M. Brown

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 25th  
year 1940 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec 1, 1931, to Jan 25, 1940;  
that I last saw her alive on Jan 24, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia  
Due to General debilitation advanced age  
Due to Multiple sarcinomatosis  
Other conditions \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Carl W. Yett (M. D. or other) \_\_\_\_\_  
Address 3855 Proctor Date signed 1-26-40

Duration \_\_\_\_\_  
Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

5 me

4 - Mrs. Robert V. ...  
Kendrick State ...

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Kenneth Page Sipe

Licensed Embalmer No. 4128

P. O. Address. 1309 Birch Creek K.C.

**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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. 390  
(c) City ..... (d) Street No. .... St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. day (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ruth Eliza Evans

(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
95

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

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

FATHER  
13. NAME

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

MOTHER  
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 27 1940 M. M. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 25 1940

22. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Septic Pneumonia  
Multiple Arteriosclerosis  
hypertensive self poisoning of Pt. ear - tube  
Date of onset

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY L. 73.

1405