

17-39
X21492
4151 SEP 24 1940 607
Registration District No.

Primary Registration District No. 58064361

Registrar's No. 44

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Portageville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

8. (a) PRINT FULL NAME

J. V. Evans 15²

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced Student

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 14 1920
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 0 16 hr. min.

9. Birthplace Portageville Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business _____

MOTHER FATHER
12. Name Lewey Evans
13. Birthplace Portageville Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Johnson
15. Birthplace Portageville Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Lewey Evans
(b) Address Portageville Mo.

17. (a) Burial (b) Date thereof 9 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Evans Cemetery

18. (a) Signature of funeral director _____
(b) Address Portageville Mo.

19. (a) Sept 6, 1940 (b) Ernest W. Cook 535
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Portageville
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30th
year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 30 1940 to Aug 30 1940
that I last saw him alive on Aug 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of base of skull

Due to _____
Due to Automobile wreck

Other conditions (Include pregnancy within 3 months of death) none

Major findings of operations none
Of autopsy none made

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident (Car)
(b) Date of occurrence Aug 30, 1940
(c) Where did injury occur? Portageville, New Madrid Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
2 miles from town on Hwy # 61
While at work? no (Specify type of place) (e) Means of injury Car wreck
23. Signature E. O. Conrad (M. D. or other) 1940
Address Portageville, Mo. Date signed 8-31-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

210m
98

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. **607**

Primary Registration District No. **4361**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **New Madrid**
 (b) City or town **Parsonsville**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME **J. V. Evans**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color **Black** 6. (a) Single, ~~widowed~~, **student**, divorced
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	20	-	16	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **30** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **fracture of base of skull**

automobile wreck

Due to **blinding from anthrax eye infection**
hit only the ground in turning
did not the car.

Other conditions **accident occurred on highway 61**
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **acc**

(b) Date of occurrence **aug 30. 40**

(c) Where did injury occur **Parsonsville mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
I'm from town Hwy 61
(Specify type of place)

While at work: _____ (e) Means of injury _____

23. Signature **R. C. Leonard** (M. D. or other) **M.D.**

Address **Parsonsville, Mo** Date signed **10-22-40**

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **29189**

Registration District No. **609**

Primary Registration District No. **4361**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Portageville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community _____ years, months or days) **11 - mo.** (Specify whether

3. (a) PRINT FULL NAME **J. V. Evans**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **black** 6. (a) Single, widowed, divorced, **Student**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **20** Months **0** Days **16** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **9-6-1940** (b) **Mary W. Cook**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **New Madrid**

(c) City or town **Portageville**
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Apr** day **30** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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? _____ (City or town) _____ (County) _____ (State)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL