

No. 2-5-42-5-17-39 X32873

FILED DEC 11 1943
Registration District No. **3383**

Primary Registration District No. **330-016-5120**

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

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Columbia Miss**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Boone County Infirmiry**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 Years**
In this community **7 1/2 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**
(c) City or town **Columbia**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 6, Boone County Infirmiry**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **EVERETT EVANS**

3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **0 Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **9** years
7. Birth date of deceased **8 - 17 - 1869**
(Month) (Day) (Year)

8. AGE: Years **74** Months **3** Days **6**
If less than one day .hr. .min.

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Matthew Evans**

MOTHER FATHER
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Boone County Infirmiry**
(b) Address **Route 6, Columbia, Mo.**

17. (a) **Burial** (b) Date thereof **11-26-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **Columbia Cemetery**

18. (a) Signature of funeral director **Barbara F. Searce**
(b) Address **Columbia, Mo.**

19. (a) **11-26-43** (b) **Edna H. Barber**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **23**
year **1943** hour **2:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **July 10**
1943, to **Nov 12** **1943**
that I last saw him alive on **Nov 14** **1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Duration **3 weeks**

Due to **Arteriosclerosis**

Due to

Other conditions **Chronic nephritis** **6 mos**
(Include pregnancy within months of death)

Major findings: **due to hypercholesterolemia**
Of operations **None** PHYSICIAN

Of autopsy **none** **1/31/43**
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).....
(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 **W.K. McCaskey** (M. D. or other) **0**
Address **Columbia** Date signed **11-26-43**

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

M. V. Whitaker

Licensed Embalmer No. *3893*

P. O. Address *Calumet, Mo.*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37716
Registrar's No. 285

Registration District No. (38)

Primary Registration District No. (5120)

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Everett Evans

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive.....

7. Birth date of deceased.....

Aug 17 1866
(Month) (Day) (Year)

8. AGE:

Years 74 Months 3 Days 2 If less than one day, min.

9. Birthplace.....

Mo
(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).....

(Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a).....

(Date received local registrar)

Edna H. Barber
(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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 17 Year 1943 Hour 3 minute 3 M.

21. I hereby certify that I attended the deceased from....., 19.....; that I saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....
Due to.....
Other conditions..... (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).....
(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.....

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

SUPPLEMENTARY

