

0-2
0-4-41
17-39
X29484

FILED JUL 9 1946
Registration District No. 33

Primary Registration District No. 3074

State File No.

Registrar's No. 37

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Smith Add - Rickland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)

In this community: 55 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott

(c) City or town: Sikeston
(If outside city or town limits, write "RURAL")

(d) Street No.: Smith Addition
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Sarah Pamela Evans

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

3. (c) Social Security No.: X

4. Sex: F

5. Color or race: W

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

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: 1 years

7. Birth date of deceased: 1 / 1 / 1862
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>4</u>	<u>11</u>	hr. min.

9. Birthplace: Ward Co. Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: Lige Whitten

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

14. Maiden name: Sallie Evans

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

16. (a) Informant: Mr Gurley Evans

(b) Address: Sikeston, Mo.

17. (a) Burial (b) Date thereof: 5/13/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Sikeston, Mo. R.F.D.

18. (a) Signature of funeral director: H.W. Albritton

(b) Address: Sikeston, Mo.

19. (a) 6-28-46 (b) Max J. Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 12
year 1946 hour 8 minute 45 p. M.

21. I hereby certify that I attended the deceased from 8-1 1946 to 5-12 1946
that I last saw h.M. alive on 5-1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death:
Polio m. Arida
ENCEPHALITIS

Due to:

Due to:

Other conditions:

Major findings:
Of operations:

Of autopsy:

ADDITIONAL SUPPLEMENTARY INFORMATION

22. If death was due to external causes, **RECORDED** state 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) (c) Means of injury: 0

23. Signature: [Signature] (M. D. or other).....
Address: Sikeston, Mo. Date signed: 5-25-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No.

District File Number 246-784

Date Filed 7-3-46

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.....

not embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed *John Allerton*.....

Licensed Embalmer No. 2941.....

P. O. Address Sikeston, Mo.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. July
Registrar's No. 37

Registration District No. 333

Primary Registration District No. 3074

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(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)

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 _____

3. (a) PRINT FULL NAME Sarah P. Evans

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Jan 1
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days _____ (Less than one day)
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year _____ hour _____ minute _____ M.

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

Immediate cause of death Lobar Pneumonia

Duration _____

Due to _____

Due to _____

Other conditions (Exclude pregnancy within 3 months of death) Terminal

Major findings: Examination

Of operations _____

Of autopsy 108

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 _____

SUPPLEMENTARY

EXAMINATION REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

21285

22416