

No. 2
12-45
1739
7070

Registration District No. 61

Primary Registration District No. 4107

Registrar's No.

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town El Dorado Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chambers Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 1/2 mo
(Specify whether years, months or days)
In this community 87-6-10

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar 20
(c) City or town El Dorado Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 210 High Tower
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME W. W. EVANS

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 18 1859
(Month) (Day) (Year)

8. AGE: Years 87 Months 06 Days 10 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Robert T. Evans

13. Birthplace Ky

14. Maiden name Mervena Ward

15. Birthplace Ky

16. (a) Informant Robert Evans

(b) Address Kansas City Mo

17. (a) Burial, cremation, or removal (b) Date thereof 6/28/47
(c) Place: burial or cremation Nevada Mo

18. (a) Signature of funeral director Maper Funeral Home

(b) Address El Dorado Mo

19. (a) 6-29-47 (b) J. Brandman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1947 hour 6:00 minute 30 AM
21. I hereby certify that I attended the deceased from Dec 1
1946 to June 25 1947
that I last saw him alive on June 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Peritis
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 R. Chandler (M. D. or other)

Address Eldorado Mo Date signed 5-25-47

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

X

MS
OCT 10 1980

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 *George W. Mofis*

Licensed Embalmer No. *2752*

P. O. Address *El Dorado, Ark.*

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.

duplicate

Registration District No. 61

Primary Registration District No. 4107

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town El Dorado Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Chambers Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 1/2 mo.
(Specify whether
In this community 87-6-10
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar
(c) City or town El Dorado Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 210 Hightower
(If rural, give location)
(e) Citizen of foreign country? Missouri (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME W. W. 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 wid

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

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

8. AGE: Years 87 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Teacher

11. Industry or business _____

MOTHER FATHER

12. Name Robert T. Evans
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Mernava Ward
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Evans

(b) Address Kansas City, Missouri

17. (a) burial (b) Date thereof 6/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada, Mo.

18. (a) Signature of funeral director Nafus Funeral Home

(b) Address _____

19. (a) 6/29/47 (b) J. C. Brannan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year 1947 hour _____ minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec. 1
1946 to June 25, 1947.
that I last saw h. ill arise on June 25, 1947.
and that death occurred on the date and hour stated above.
Immediate cause of death _____

senile paralis

Due to _____

Due to _____

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

R. O. Crawford
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 R. O. Crawford (M. D. or other) M. D.
Address El Dorado Spgs, Mo. Date signed 6-26-47

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

SUPPLEMENTARY

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

July

S-20334