

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32091

State File No. _____

FILED OCT 9 1953

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 373

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence</u> <u>7005</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence, 1614 Ralston</u> | | d. STREET ADDRESS (If rural, give location) <u>1614 Ralston</u> | |

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|---|--|---|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Eva</u> b. (Middle) <u>Lena</u> c. (Last) <u>Ewing</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30, 1953</u> | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u> | | 8. DATE OF BIRTH <u>Oct. 11, 1867</u> | |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Milton, Ills.</u> | | 9. AGE (In years last birthday) <u>85</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME <u>unknown Boyer</u> | | 13b. MOTHER'S MAIDEN NAME <u>Olive Rader</u> | | 14. NAME OF HUSBAND OR WIFE <u>Chas. L. Ewing (deceased)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Bernice Shubkagel, Independence, Mo.</u> | |

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>20</u> <u>years</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thromboses</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive</u> DUE TO (c) <u>Cardiovascular Disease</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>4201</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from Sept 20, 1949, to Sept 30, 1953 that I last saw the deceased alive on July 2, 1953 and that death occurred at 8 PM m., from the causes and on the date stated above.

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|--|--|---|--|---|--|
| 23a. SIGNATURE (Degree or title) <u>Ethel Watson M.D.</u> | | 23b. ADDRESS <u>129 W Lexington</u> | | 23c. DATE SIGNED <u>10-1-53</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>10/2/53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Frankfort Cemetery</u> | |
| | | 24d. LOCATION (City, town, or county) (State) <u>Frankfort, Kansas</u> | | | |

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|--|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. <u>10-2-53</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>354-0</u> | | 27. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature]</u> <u>Independence, Mo.</u> | |
|--|--|--|--|---|--|

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 4 1958

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed L. Vega E. Brown

Licensed Embalmer No. 4794

P. O. Address Independencia

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.