

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14951**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **492**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) St. Joseph		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 1/2 years		• STREET ADDRESS (If rural, give location) 3128 Sylvania St. 01170	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3128 Sylvania St.			

3. NAME OF DECEASED a. (First) David b. (Middle) H. c. (Last) Evans			4. DATE OF DEATH May 6, 1954		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH December 26, 1875		9. AGE (In years last birthday) 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (City and State or Foreign Country) Wales		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME David Evans		13b. MOTHER'S MAIDEN NAME Margaret Jones		14. NAME OF HUSBAND/OR WIFE Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Miss Rosalie Evans, 3128 Sylvania St. St. Joseph,	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Failure		DUPLICATE OF (b) Arteriosclerosis		6 hr.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		?	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **4-16-1954**, to **5-6-1954**, that I last saw the deceased alive on **5-6-1954**, and that death occurred at **3:05 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert W. Keiser, M.D. (Degree or title)		23b. ADDRESS St Joseph, Mo		23c. DATE SIGNED 5-6-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 5/6/1954		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Chillicothe, Missouri	
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DATE REC'D BY LOCAL REG. May 13, 1954		REGISTRAR'S SIGNATURE Lothar M. Allison 485		25. FUNERAL DIRECTOR'S SIGNATURE Heston-Bowman		ADDRESS St Joseph Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

007 1 R 1957

MAY 1

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.....
Signature of Student Embalmer

Signed *W.E. Edmentow*.....

Licensed Embalmer No. *478*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.