

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017335
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 508

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hosp.</u>		Length of stay in lb <u>23 yrs.</u>	0396 d. STREET ADDRESS (If outside, give location) <u>840 S. New</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Juan</u> Middle <u>Lawson</u> Last <u>Evans</u>			4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1906-52</u>
9. AGE (In years, if UNDER 1 YEAR; if UNDER 24 HRS. show birthday) Months Days Hours Min.		9. AGE (In years, if UNDER 1 YEAR; if UNDER 24 HRS. show birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sr. Correct. Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Med. Center</u>	11. BIRTHPLACE (City and state or country) <u>Down, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>David H. Evans</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Evans</u>	14. NAME OF HUSBAND OR WIFE <u>Flossie J. Evans</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (World War I or later) <u>Yes</u> (<u>World War I</u>)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Flossie J. Evans-Springfield, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Hepatic Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chinchois of liver</u> DUE TO (c) <u>arteriosclerotic generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 months</u> <u>5 yrs</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>4-28-59</u> to <u>5-22-59</u> and last saw ^{him} alive on <u>5-22-59</u> Death occurred at <u>3 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from <u>4-28-59</u> to <u>5-22-59</u> and last saw ^{him} alive on <u>5-22-59</u> Death occurred at <u>3 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Michael J. Clarke M.D.</u>		22b. ADDRESS <u>1636 So. Glenstone, Springfield, Missouri</u>	22c. DATE SIGNED <u>5-25-59</u>
23a. BURIAL, CREATION, REBURY <u>Reburied</u>	23b. DATE <u>5-24-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cavalon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Livingston County, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey-Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-26-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

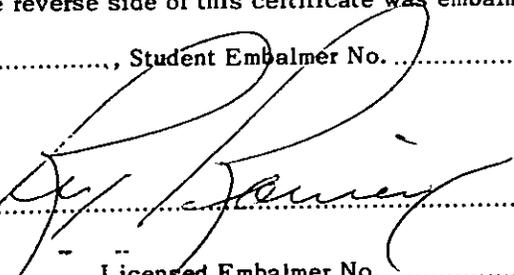
Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MS JUN 1957

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  Licensed Embalmer No. P. O. Address

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.