

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020448

STATE FILE NUMBER
Registrar's No. 657

Registration District No. 042 Primary Registration District No. 1000

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp. 70yrs Length of stay in lb 70yrs
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph, Inside Limits Yes No
STREET ADDRESS 402 Ohio outside, give location Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
William S Evans
4. DATE OF DEATH Month Day Year
June 20, 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH Mar. 4, 1888
9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler marker
10b. KIND OF BUSINESS OR INDUSTRY Shamrod Boiler De'alt, Mo
11. BIRTHPLACE (City and state or country) De'alt, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Samuel Evans
13b. MOTHER'S MAIDEN NAME Martha Brakes
14. NAME OF HUSBAND OR WIFE Ruby Evans

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. 491-09-1837
17. INFORMANT Address Ralph Evans St. Joseph Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Liver
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH Unk.
19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE
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. INJURY OCCURRED WHILE AT NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6/8/59 to 6/20/59 and last saw her alive on 6/19/59
Death occurred at 2:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Free or title)
22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.
22c. DATE SIGNED 6/21/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6/22/59
23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Mo

24. FUNERAL DIRECTOR ADDRESS Supp Funeral Home, St. Joseph Mo
25. DATE RECD. BY LOCAL REG. June 26, 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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, ~~of~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John E. Rupp*
Licensed Embalmer No. *3986*
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.