

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-046814**  
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 174

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1963

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Length of stay in lb <b>2 yr. 8 mo</b>	c. CITY OR TOWN <b>Mansfield</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #3</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>--</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last <b>Evans -- Schoonover</b>			4. DATE OF DEATH Month Day Year <b>11 11 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-1880</b>
9. AGE (last birthday) <b>82</b>		IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Furniture Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Used Furniture</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Jacob Schoonover</b>	
13b. MOTHER'S MAIDEN NAME <b>Addie Shaw</b>		14. NAME OF HUSBAND OR WIFE <b>Widowed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT Address <b>State Hospital No. 3, Hospital records-Nevada, Missouri.</b>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> 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) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>None</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from <b>The Staff March 21, 1961</b> to <b>Nov. 11, 1963</b> and last saw <sup>him</sup> <del>him</del> alive on <b>November 11, 1963</b> . Death occurred at <b>7:25 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Or Melvin M.D.</i>		22b. ADDRESS <b>State Hospital #3, Nevada, Mo.</b>	22c. DATE SIGNED <b>11-11-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>November 11 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mansfield Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Mansfield Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ferry Funeral Home, Nevada, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-15-1963</b>	26. REGISTRAR'S SIGNATURE <i>Anna E. Ferry</i>

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 Ray E. Ireland

Licensed Embalmer No. 5052

P. O. Address Newark Mo.

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.