

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25619**

XC-1 863 322
Reg # 87185
FILED AUG 8 1950

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **1850**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY WHITE	
b. CITY (If outside corporate limits, write RURAL and give township) JEFF. BRKS, MO		c. CITY (If outside corporate limits, write RURAL and give township) CARMI	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		d. STREET ADDRESS (If rural, give location) 610 North 7th St.,	

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM	b. (Middle) F.	c. (Last) DAVIDSON	4. DATE OF DEATH (Month) (Day) (Year) XXXX AUGUST 1, 1950
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 5-25-93	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) KENTUCKY	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME ROBERT DAVIDSON	13b. MOTHER'S MAIDEN NAME CATHERINE WILSON	14. NAME OF HUSBAND OR WIFE MAYSELLE W.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. BRKS, MO.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION CARCINOMA OF LIVER - UNDETERMINED PRIMARY SITE		INTERVAL BETWEEN ONSET AND DEATH 156A
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **7-26**, 19**50**, to **8-1**, 19**50**, and that death occurred at **7:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE L.E. Stilwell M.D. L.E. STILWELL, CHIEF, PROF. SERVICES	(Degree or title)	23b. ADDRESS JEFF. BRKS, MISSOURI	23c. DATE SIGNED 8-1-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 8-1-50	24c. NAME OF CEMETERY OR CREMATORY MAPLERIDGE CEMETERY	24d. LOCATION (City, town, or county) (State) CARMI TOWN ILLINOIS
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DATE REC'D BY LOCAL REG. 8-2-50	REGISTRAR'S SIGNATURE Hubert L. Stouck, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ROWLAND MORTUARY, St. Louis, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Je 6911

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Ronald O. Yahrke*

Signed.....
Student Embalmer

Licensed Embalmer No. *3917*

P. O. Address *St Louis 10 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 this body is not embalmed, fact should be so stated above.