

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4504

State File No.

MAR 15 1954

128

2000

272

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <p align="center">Greene</p>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p align="center">Missouri</p>				b. COUNTY <p align="center">Bates</p>	
b. CITY OR TOWN <p align="center">Springfield</p>		c. LENGTH OF STAY (in this place) <p align="center">8 days</p>		c. CITY OR TOWN <p align="center">Rockville</p>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center">Springfield Baptist Hospital</p>				e. STREET ADDRESS (If rural, give location) <p align="center">No street address</p>				0070	
3. NAME OF DECEASED (Type or Print)		a. (First) <p align="center">LAURA</p>		b. (Middle) <p align="center">DAVIS</p>		c. (Last) <p align="center">BOWEN</p>		4. DATE OF DEATH (Month) (Day) (Year) <p align="center">March 10-1954</p>	
5. SEX <p align="center">Female</p>		6. COLOR OR RACE <p align="center">White</p>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <p align="center">Widowed</p>		8. DATE OF BIRTH <p align="center">Jan 19, 1867</p>		9. AGE (in years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <p align="center">87</p>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center">Housewife</p>			10b. KIND OF BUSINESS OR INDUSTRY <p align="center">Own Home</p>		11. BIRTHPLACE (City and State or Foreign Country) <input checked="" type="checkbox"/> <p align="center">Holden, Missouri</p>			12. CITIZEN OF WHAT COUNTRY? <p align="center">U.S.A.</p>	
13a. FATHER'S NAME <p align="center">Wilburn Davis</p>			13b. MOTHER'S MAIDEN NAME <p align="center">Armintha Miller</p>			14. NAME OF HUSBAND OR WIFE <p align="center">-----</p>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p align="center">no</p>		16. SOCIAL SECURITY NO. <p align="center">none</p>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <p align="center">Mrs S. R. Midkiff, Springfield, Mo.</p>					
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)				<p align="center">Cerebral Thrombosis</p>				<p align="center">7 days</p>	
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				<p align="center">arterio sclerosis</p>	
DUE TO (b)								<p align="center">years</p>	
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"/>	
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)		= 332 X			
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 Oct. 1952 to Mar. 10, 1954, that I last saw the deceased alive on Mar 9, 1954, and that death occurred at 4:03A m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <p align="center">M.D.</p>				23b. ADDRESS <p align="center">Springfield, Mo.</p>			23c. DATE SIGNED <p align="center">3-10-54</p>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center">Removal</p>		24b. DATE <p align="center">March 10, 1954</p>		24c. NAME OF CEMETERY OR CREMATORY <p align="center">Unknown</p>		24d. LOCATION (City, town, or county) (State) <p align="center">Applleton City, Missouri</p>			
DATE REC'D BY LOCAL REG. <p align="center">3-11-54</p>		REGISTRAR'S SIGNATURE <p align="center">Earl Williamson</p>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <p align="center">Alma Schmeier, Springfield, Mo. B.W.</p>				

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Carl J. Gleason*

Licensed Embalmer No. *470*

P. O. Address *Springfield*

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.