

FILED MAR 16 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8789

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5725 Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <u>Macon 4</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon 610</u>	
b. CITY OR TOWN <u>Macon Rural</u>		c. CITY OR TOWN <u>Berwick</u>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>0</u>
c. LENGTH OF STAY (in this place) <u>2 days</u>		e. STREET ADDRESS (If rural, give location) <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lakeview Rest Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Barber</u> c. (Last) <u>Davis</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-28-55</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-6-1863</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kearneyville Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>James Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Stacy</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
---------------------------------------	--	--------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Binder</u>	ADDRESS <u>Macon Mo</u>
---	----------------------------------	--	-------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> 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"/> <u>332 X</u>
------------------------------	--	---

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) <u>Berwick Mo</u>
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 2-17-1955 to 2-28-1955, that I last saw the deceased alive on 2-22-1955, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank H. Coffin D.O.</u>	23b. ADDRESS <u>Berwick Mo</u>	23c. DATE SIGNED <u>3-3-55</u>
--	--------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-2-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Louise Brown</u>	24d. LOCATION (City, town, or county) (State) <u>Callao Mo</u>
---	-------------------------	--	--

DATE REC'D BY LOCAL REG. <u>3/4/55</u>	REGISTRAR'S SIGNATURE <u>W. M. Neely</u>	185	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Edwards</u>	ADDRESS <u>Berwick Mo</u>
--	--	-----	---	---------------------------

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

RECEIVED 3, 10, 55
MACON COUNTY HEALTH DEPARTMENT
County File No. 3, 55, 33
Date Filed 3, 15, 55

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 *J. H. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Brewer 2*

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.