ept. Health,
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

36499
STATE FILE NUMBER

FILED OCT 22 1957

Registration District No. 170 Primary Registration District No. 4264 Registrar's No. 166

1. PLACE OF DEATH
a. COUNTY LACLEDE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CONWAY, MO — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home - Conway. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY LACLEDE
c. CITY OR TOWN CONWAY MO — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS — (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First GEORGE Middle S. Last DAVIS
4. DATE OF DEATH Month OCT Day 9 Year 1957
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH Aug 29 1874
9. AGE (In years last birthday) 83 — 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) RET SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) WISCONSIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME HARRY DAVIS
13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES SPANISH AM.
16. SOCIAL SECURITY NO.
17. INFORMANT ADELINE ROOT Address ROBBINSDALE MINN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
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): no attending Physician 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] 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 ____ to ____ and last saw her/him alive on ____
Death occurred at 6:30 Am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Ella S. Clay (Degree or title) Local Registrar
22b. ADDRESS Lebanon, Mo.
22c. DATE SIGNED 10-10-1957

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 10-11-1957
23c. NAME OF CEMETERY OR CREMATORY NATIONAL
23d. LOCATION (City, town, or county) SPRINGFIELD (State) MO

24. FUNERAL DIRECTOR BARBER-EDWARDS MARSHFIELD ADDRESS
25. DATE RECD. BY LOCAL REG. 10-10-1957
26. REGISTRAR'S SIGNATURE Ella S. Clay
(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

424-0

OCT 28 1957

VS DEC 4 1959

Received 10-21-57

Laclede County Health Unit

File No. 166

Date Filed 10-21-57

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 George Stapp

Licensed Embalmer No. 3161

P. O. Address Mtn Grove 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.