

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37333**
Registrar's No. **9600**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 5 WKS.	c. CITY OR TOWN De Soto
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mo. Baptist Hosp.		e. STREET ADDRESS (If rural, give location) 29 RURAL RT. #3	

3. NAME OF DECEASED (Type or Print) a. (First) NORA	b. (Middle) BELLE	c. (Last) DAVIS	4. DATE OF DEATH (Month) (Day) (Year) OCT, 12 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 1 1903
9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) PEA RIDGE Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME W M COLLINS	

13b. MOTHER'S MAIDEN NAME MADIE DILL	14. NAME OF HUSBAND OR WIFE PERCY E. DAVIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. YES UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME PERCY E. DAVIS	
ADDRESS De Soto RT. #3	

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) Multiple Myeloma (Plasma Cell Myeloma)	ANTECEDENT CAUSES		2 yrs
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
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 203x	20. AUTOPSY? 1 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)
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 **AUG 12, 1957** to **OCT 12, 1957**, that I last saw the deceased alive on **OCT 12, 1957**, and that death occurred at **4:10 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Richard J. Jones MD	(Degree or title) MD	23b. ADDRESS 3720 Washington	23c. DATE SIGNED OCT 14, 1957
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE OCT. 12 1957	24c. NAME OF CEMETERY OR CREMATORY BETHLEHEM	24d. LOCATION (City, town, or county) (State) GRUBVILLE Mo.

DATE REC'D BY LOCAL REG. OCT 15 57	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Donnell B. Dietrich	ADDRESS De Soto Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

5. No. 300
V. 10. 48

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 *Samuel B. Dietrich*.....

Licensed Embalmer No.. *7104*.....

P. O. Address *aled to Ma*.....

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.