

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000446  
STATE FILE NUMBER 8

FILED JAN 19 1959 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 8

300 2  
1-57

1. PLACE OF DEATH a. COUNTY <u>Calloway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Moberly</u> 0883 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE Hosp. #1</u>		Length of stay in lb <u>2 1/2 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>328 N. 4th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIE JOHN DAVIES</u>			4. DATE OF DEATH Month Day Year <u>JAN 1 1959</u>		
---	--	--	---	--	--

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/1879</u>	9. AGE (In years at birthday) <u>79</u>	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) <u>TRUCK FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	11. BIRTHPLACE (City and state or country) <u>UNK WALES</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
--	--	--	---

13a. FATHER'S NAME <u>UNK JAMES DAVIES</u>	13b. MOTHER'S MAIDEN NAME <u>UNK ANNE DAVIES</u>	14. NAME OF HUSBAND OR WIFE <u>UNK RACHEL DAVIES</u>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>UNK.</u>	17. INFORMANT Address <u>Hospital Records.</u>
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE Parotitis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral Arteriosclerosis</u>	
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>DEC-11-1959</u> to <u>DEATH</u> and last saw her/him alive on <u>—</u> Death occurred at <u>JAN 1 7:40</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>James K. Pitterbach M.D.</u>	22b. ADDRESS <u>State Hosp. #1</u>	22c. DATE SIGNED <u>1/1/59</u>
---	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>JAN 2, 1959</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>	23d. LOCATION (City, town, or county) <u>MOBERLY</u>	(State) <u>MO</u>
---	-----------	--	---	----------------------

24. FUNERAL DIRECTOR <u>MAHAN FUNERAL SERVICE MOBERLY MO</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Jan-16-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
---	---------	--	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 22 1958

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 *John A. Green* .....

Licensed Embalmer No. *2815* .....

P. O. Address *Madison, 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.