Health, Welfare Public Service

300 -57 /

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006160

STATE FILE NUMBER

FILED FEB 19 1959 Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 17

1. PLACE OF DEATH
a. COUNTY: Jefferson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Meramec — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Cedar Hill Mo — Length of stay in Ib: 6 mos

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN: Malden — Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Octavia — Middle: — Last: Davis

4. DATE OF DEATH: Month 2 — Day 5 — Year 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 3/15/1896

9. AGE (In years last birthday): 62 — 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): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public school

11. BIRTHPLACE (City and state or country): Malden Mo

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: James Seelinger

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Widow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 498-34-0639

17. INFORMANT: Ida Carruthers — Address: St Louis Mo

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Brain hemorrhage due to rupture of arteriosclerotic cerebral artery	1 hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic hypertensive cardiovascular disease	2 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 443X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 8-25-58, to 2-5-59 and last saw her/him alive on 1-2-59
Death occurred at 6:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M.D.

22b. ADDRESS: 634 N. Grand Blvd.

22c. DATE SIGNED: 2/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 2/6/59

23c. NAME OF CEMETERY OR CREMATORY: Malden Cem.

23d. LOCATION (City or town, county) (State): Poplar Bluff Mo

24. FUNERAL DIRECTOR — ADDRESS: Frank-Cotrell Chapel Poplar Bluff Mo

25. DATE RECD. BY LOCAL REG.: 2-6-59

26. REGISTRAR'S SIGNATURE: Robert E. Bower

(Licensed Embalmer's Statement on Reverse Side)

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 V E Morris

Licensed Embalmer No. 3360

P. O. Address St. Louis, 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.