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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009991
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 54

1. PLACE OF DEATH
a. COUNTY Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Louise G. Wallace — Length of stay in lb 6 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Laclede
c. CITY OR TOWN Lebanon — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 366 Lincoln St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Joseph Middle Washington Last Davis

4. DATE OF DEATH Month April Day 1 , Year 1959

5. SEX male

6. COLOR OR RACE white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH May 7, 1878

9. AGE (In years last birthday) 80 — 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) farming

10b. KIND OF BUSINESS OR INDUSTRY farming

11. BIRTHPLACE (City and state or country) Camden Co., Missouri

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

13a. FATHER'S NAME Bill Davis

13b. MOTHER'S MAIDEN NAME Christina Traw

14. NAME OF HUSBAND OR WIFE Myrtle Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. none

17. INFORMANT Address Louise G. Wallace Hospital, Lebanon, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia Bilateral Bronchial — INTERVAL BETWEEN ONSET AND DEATH 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Following Upper Resp. Infection
DUE TO (c) 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [X] 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 May 3-1946, to April 1, 1959 and last saw her/him alive on April 1, 1959
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) Paul A. Jontius MD

22b. ADDRESS Knight Bldg., Lebanon, Mo.

22c. DATE SIGNED April 3, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE 4-3-59

23c. NAME OF CEMETERY OR CREMATORY Mt. Rose Memorial Park

23d. LOCATION (City, town, or county) (State) Lebanon, Mo.

24. FUNERAL DIRECTOR [signature] ADDRESS Lebanon, Mo.

25. DATE RECD. BY LOCAL REG. 4-3-1959

26. REGISTRAR'S SIGNATURE Della L. Day

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Date Filed APR 13 1959

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 .....

Licensed Embalmer No. 38-48

P. O. Address .....

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.