

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010012

STATE FILE NUMBER

FILED MAR 24 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 28

300
1-57 0

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lexington</u> <u>0540</u> 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>Lex. Memorial Hosp; 1 Day</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>410 S. 24th. St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>BELVA</u> First <u>LEE</u> Middle <u>DAVIS</u> Last			4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>		
---	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1898</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-------------------------	----------------------------------	---	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Ethyl, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
---	--	---	--

13a. FATHER'S NAME <u>Horace Eitel</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Thad Davis</u>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>NO.</u>	16. SOCIAL SECURITY NO. <u>497-26-2807</u>	17. INFORMANT <u>Thad Davis, Lexington, Mo.</u> Address
--	---	---

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>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
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)		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 _____ 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>Feb 1950</u> to <u>March 6, 1959</u> and last saw her alive on <u>3-5-59</u> Death occurred at <u>3:00</u> a. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joe W Ward</u> (Degree or title) M.D. ⁰	22b. ADDRESS <u>Lexington, Mo.</u>	22c. DATE SIGNED <u>3-7-59</u>
---	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>MARCH 10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Mem. Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Carrollton, Mo.</u>
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR <u>Naval P. Walker, Lexington, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-19-59</u>	26. REGISTRAR'S SIGNATURE <u>Wm. S. G. ...</u>
--	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Harold J. Walker*

Licensed Embalmer No. *45-88*

P. O. Address *Sturington, Md*

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.