

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016464

STATE FILE NUMBER

FILED MAY 13 1959 Registration District No. 340 Primary Registration District No. 6132 Registrar's No. 45

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|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Stoddard</b>  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>                   |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Bernie Liberty</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <b>Bernie</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>County road enroute to hospital</b>   |                                  | Length of stay in lb  | d. STREET ADDRESS (If outside, give location)<br><b>Rural route # 1</b>   |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Freda</b> Middle <b>Lois</b> Last <b>Davis</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>April</b> Day <b>19</b> Year <b>1959</b>   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 13, 1933</b>   | 9. AGE (In years last birthday) <b>26</b><br>IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b><br>IF UNDER 24 HRS. <b>0</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Bernie, Missouri</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13a. FATHER'S NAME<br><b>Walter Lamunion</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Josie Lamunion</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Cratis E. Davis</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   | 17. INFORMANT<br>Address<br><b>Cratis E. Davis Rt. 1, Bernie, Mo.</b>   |   |   |
| 18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fractured skull and internal injuries</b>                                      |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                  |   |   |   | DUE TO (b) _____<br>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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input checked="" 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.)<br><b>Two car accident and above person was thrown from car.</b> |   |   |
| 20c. TIME OF INJURY<br>Hour <b>3: p</b> Month, Day, Year <b>4-19-59</b>   |                                  |   | 103   |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Country road</b>   | 20f. CITY, TOWN, OR LOCATION<br><b>Bernie Rfd. 1 Stoddard Missouri</b>  |   | STATE   |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____<br>Death occurred at <b>3:30 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |   |   |
| 22a. SIGNATURE<br><b>Marion Watkins</b> (Degree or title)<br><b>Coroner 3</b>   |                                  |   | 22b. ADDRESS<br><b>Dexter, Missouri</b>   |   | 22c. DATE SIGNED<br><b>4-21-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>4-22-59</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bernie Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Bernie, Missouri</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Duffie-Rainey Funeral Home Bernie</b>  |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-4-59</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Anita M. Garner</b><br>Dep Reg.   |   |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

*Raymond L. Duffie*

Licensed Embalmer No. *4798*

P. O. Address *Berme, 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.