

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025799

FILED VS. AUG 5 1959

Primary Registration District No. 5655 Registrar's No. 86

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Lawrence				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Laclede						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in 1b 1536 days		c. CITY OR TOWN Lebanon		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Springfield Road		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joe Middle S. Last Davis				4. DATE OF DEATH Month July Day 28 Year 1959						
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-15-77		9. AGE (last birthday) 81		IF UNDER 1 YEAR Months Days 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		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Charley Crow			13b. MOTHER'S MAIDEN NAME Mary Burbin			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown			16. SOCIAL SECURITY NO. unknown		17. INFORMANT San. records, Mo. State San., Mt. Vernon Mo.				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) Massive Pulmonary Hemorrhage								INTERVAL BETWEEN ONSET AND DEATH few min.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Pulmonary tuberculosis, Far advanced, active		DUE TO (c)		Interval between onset and death 4 1/2 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <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 5 - 14 - 55 , to 7 - 28 - 59 and last saw him xx alive on 7 - 28 - 59				Death occurred at 5:30 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Donald R. Wilson M.D.</i> (Degree or title)				22b. ADDRESS Mt. Vernon, Missouri				22c. DATE SIGNED 7-29-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-29-59	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Lebanon, Missouri		(State)			
24. FUNERAL DIRECTOR <i>Wm L. Forest</i> ADDRESS Mo. Vernon Mo.			25. DATE RECD. BY LOCAL REG. 7-29-59		26. REGISTRAR'S SIGNATURE <i>Cecil Hendricks</i>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JUL 19 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed May L Forsyth

Licensed Embalmer No. 4252

P. O. Address W. W. W. W.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.