

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028005

FILED VS AUG 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 240

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Adair County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SULLIVAN</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BENTON TWP.</u>		Length of stay in 1b <u>MINUTES</u>		c. CITY OR TOWN <u>GREEN CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>ON HIGHWAY 6 2 MI. WEST</u> INSTITUTION <u>OF KIRKSVILLE ENROUTE TO HOSP.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NO STREET ADDRESS</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maynard Conway Davis</u>				4. DATE OF DEATH Month Day Year <u>August 3 1959</u>				
5. SEX <u>MALE</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>MAR. 1, 1891</u>	9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. FARMING</u>		11. BIRTHPLACE (City and state or country) <u>NEW BOSTON, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>T. R. DAVIS</u>			13b. MOTHER'S MAIDEN NAME <u>ELENORA WRIGHT</u>			14. NAME OF HUSBAND OR WIFE <u>LORA WADUM DAVIS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Lora Davis, Green City, Mo.</u>			
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>RECENT MYOCARDIAL INFARCTION POSTERIOR PORTION L. VENTRICLE</u> DUE TO (b) _____ DUE TO (c) <u>(PATIENT DEAD ON ARRIVAL AT HOSPITAL)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (g) <u>L. VENTRICULAR HYPERTROPHY - PLEURAL ADHESIONS</u> 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 checked="" type="checkbox"/> NO <input 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. <u>8 p.m.</u>			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 <u>DID NOT ATTEND</u> and last saw her/him alive on _____ Death occurred at <u>D.G.A.</u> <u>5:50 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Carl Kullbueck, M.D.</u>				22b. ADDRESS <u>Kullbueck, Mo</u>			22c. DATE SIGNED <u>8-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Aug 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Green City Missouri</u>				
24. FUNERAL DIRECTOR <u>Glen E. Hartman, Green City, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 13, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Rottloff</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EARL BAUGHMAN, JR., D.O.

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 Earl P. Kent

Licensed Embalmer No. 4689
P. O. Address Green City

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.