

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 3 1959 59

59-029570

Registration District No. _____ Primary Registration District No. 4249 Registrar's No. 57

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jefferson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hillsboro		Length of stay in 1b 2 1/2 Days		c. CITY OR TOWN Manchester		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cedar Grove Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) P.O. Box 61		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Owen Middle W. Last Davis				4. DATE OF DEATH Month Aug. Day 19th 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 5-12-1892		9. AGE (last birthday) 67		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) Ret. Clerk			10b. KIND OF BUSINESS OR INDUSTRY Electric Co.		11. BIRTHPLACE (City and state or country) Selina, Ohio			12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME James Davis			13b. MOTHER'S MAIDEN NAME Nettie Stauffer			14. NAME OF HUSBAND OR WIFE Lucille N. Davis							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 488-05-7376		17. INFORMANT Marjorie Rollhaus, RR# 1, Eureka, 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) Cerebral Vascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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										INTERVAL BETWEEN ONSET AND DEATH 5 days 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 _____ a.m. _____ 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 May 1958 to Aug. 19, 1959 and last saw ^{her} him alive on Aug. 17, 1959 Death occurred at 2:10 P m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Robert S. Lawrence, M.D.</i> (Degree or title)						22b. ADDRESS 1502 Cass Av			22c. DATE SIGNED 8-20-59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-21-59		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.			23d. LOCATION (City, town, or county) St. Louis, Co, Mo.			(State)			
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 8-21-59		26. REGISTRAR'S SIGNATURE <i>Oliver [Signature]</i>					

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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 J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address St. L.

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.