

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030197

FILED VS. AUG 24 1959/16

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 321

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>ST FRANCOIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST FRANCOIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Francois Twp. FARMINGTON - Rural</b>		c. CITY OR TOWN <b>FARMINGTON</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MINERAL AREA OSTEOPATHIC HOSPITAL</b>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>VIRGINIA BELL WARREN</b>	4. DATE OF DEATH Month Day Year <b>August 14 1959</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 8 1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>RED BUD ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>THOMAS DAVIS</b>	13b. MOTHER'S MAIDEN NAME <b>LOUISA THEASTER</b>	14. NAME OF HUSBAND OR WIFE <b>ROBERT DAVIS</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT <b>ROBERT DAVIS</b>	Address <b>FARMINGTON MO</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transition + debilitation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Carcinomatosis</b>		<b>4 weeks</b>
	DUE TO (c) <b>Carcinoma of Liver</b>		<b>unknow</b>
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 checked="" 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.)
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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
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21. I attended the deceased from <b>Aug 1, 1959</b> to <b>Aug 14, 1959</b> and last saw her/him alive on <b>Aug 14, 1959</b> Death occurred at <b>8:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>M. C. ...</i>	22b. ADDRESS <b>Farmington</b>	22c. DATE SIGNED <b>8-17-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>AUGUST 17 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NOBBLICK</b>	23d. LOCATION (City, town, or county) <b>NOBBLICK MISSOURI</b>
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24. FUNERAL DIRECTOR <b>C H COZAN FUNERAL HOME FARMINGTON</b>	25. DATE RECD. BY LOCAL REG. <b>Aug 17, 1959</b>	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OSU/C 007/ SN

**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 *C. H. Cozart*  
Licensed Embalmer No. 40  
P. O. Address Farmingdale

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.