

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
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Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 649

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia, Missouri		Length of stay in lb 15 days		c. CITY OR TOWN Lexington, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION University of Missouri Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1515 Main Street		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Lola Elizabeth Deshields Anderson Davis				4. DATE OF DEATH Month Day Year December 31, 1959					
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1887	9. AGE (last birthday) 72	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) Home maker			10b. KIND OF BUSINESS OR INDUSTRY Lead Hill, Arkansas		11. BIRTHPLACE (City and state or country) yes, U.S.		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME Calvin Deshields			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE William J. 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. -	17. INFORMANT Address Mr. William J. Davis					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) 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							INTERVAL BETWEEN ONSET AND DEATH Several yrs.		
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 Columbia		COUNTY Boone		STATE Mo.	
21. I attended the deceased from 12-16-59 to 12-31-59 and last saw ^{him} alive on 12-31-59 Death occurred at 3:40 P.m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Robert E. Scuffeleman M.D.				22b. ADDRESS Univ. of Mo. Med. Center		22c. DATE SIGNED 12-31-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-31-1959	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) LEXINGTON, Mo				
24. FUNERAL DIRECTOR Parker Funeral Service, Columbia, Mo				ADDRESS Dec 31 1959		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE Mrs R E Palmer	

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. W. Phillips

Licensed Embalmer No. 4887

P. O. Address Columbus, W.

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.