

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960

-60-044503

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3263

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b	c. CITY OR TOWN <u>ROBERTSON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>358 WOODLAND</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE DAVIDSON</u>			4. DATE OF DEATH Month Day Year <u>NOV. 7 1960</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state of country) <u>WEST POINT, MISS.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>JOE BRAZILE</u>	13b. MOTHER'S MAIDEN NAME <u>unk.</u>	14. NAME OF HUSBAND OR WIFE <u>JAMES DAVIDSON</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT Address <u>ROSIE DAVIDSON 350 FAIRVIEW</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Renal Failure</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Bilateral Ureteral Obstruction</u>	
	DUE TO (c) <u>Carcinoma of Cervix</u>	<u>1 year?</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Arteriosclerosis</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
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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.)
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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 10-7-60 to 11-7-60 and last saw her ^{her} _{him} alive on 11-7-60
Death occurred at 12:25 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul W. Schaper M.D.</u>	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>11-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>WEST POINT, MISS</u>
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24. FUNERAL DIRECTOR ADDRESS <u>B. WADE GRANBERX 4202 FINNEY</u>	25. DATE RECD. BY LOCAL REG. <u>11-11-60</u>	26. REGISTRAR'S SIGNATURE <u>Jahn C. Murphy M.D.</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.