

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029611

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 325

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

FILED AUG 5 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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> COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Length of stay in 1b <b>11 day's</b>	c. CITY OR TOWN <b>Farmington</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route - #2</b>
3. NAME OF DECEASED (Type or print) First <b>Maudee</b> Middle <b>Belle</b> Last <b>Davidson</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31st.</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1885 - 77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> IF UNDER 24 HR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (City and state or country) <b>Reynolds Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William R. Hill</b>		13b. MOTHER'S MAIDEN NAME <b>Louisa McCabe</b>	
14. NAME OF HUSBAND OR WIFE <b>George Davidson</b>		17. INFORMANT Address <b>Missouri</b> <b>Mrs. Lillian Hartshorn, Farmington</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO.	
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>Pulmonary Embolus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 minute</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Postoperative state - obstetrical procedure</b>			<b>2 hrs</b>
DUE TO (c) <b>Ampullary Common duct stone</b>			<b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis, H.S.H.D., Bile duct calculi</b>			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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>July 22, 1963</b> to <b>July 31, 1963</b> and last saw her alive on <b>July 31, 1963</b> Death occurred at <b>6:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>George L. White M.D.</b>		22b. ADDRESS <b>Farmington Mo</b>	22c. DATE SIGNED <b>8-1-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/2/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>K OF P Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Francois, Missouri</b>
24. FUNERAL DIRECTOR <b>C.Z. Boyer &amp; Son Desloge, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Aug 1, 1963</b>	26. REGISTRAR'S SIGNATURE <b>Eather Rudloff</b>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 B. T. Bayer

Licensed Embalmer No. 3660

P. O. Address Desloge, Mo

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.