

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031278

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 602

FILED SEP 12 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in lb <u>84 yrs.</u>	c. CITY OR TOWN <u>Columbia</u>
c. FULL NAME OF (if NOT in hospital, give location) <u>504 Lyons St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>504 Lyons St.</u>
3. NAME OF DECEASED (Type or print) <u>Annie B. Davis</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (last birthday) <u>84 years</u>
13a. FATHER'S NAME <u>Tate Sanders</u>		13b. MOTHER'S MAIDEN NAME <u>Rosie Monroe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		17. INFORMANT <u>George W. Davis</u> Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial insufficiency</u>		<u>2 wks.</u>	
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		<u>several yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus, 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	
19. WAS AUTOPSY PERFORMED? YES <input 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 <u> </u> a.m. <u> </u> 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 <u>Columbia, Mo.</u>	
21. I attended the deceased from <u>1960</u> to <u>present</u> and last saw her/him alive on <u>15 August, 1963</u> Death occurred at <u>11:00 p. m. 8/29/63</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>3 Sept 63</u>	
22a. SIGNATURE <u>J. Denningshoff, MD</u> (Degree or title)		22b. ADDRESS <u>Columbia, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 4, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Celestial</u>	23d. LOCATION (City, town, or county) <u>McBaine, Mo.</u>
24. FUNERAL DIRECTOR <u>Mrs. Stuart Parker, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 3, 1963</u>	
		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

0-08

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.