

FILED MAR 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5773

BIRTH NO. _____ REG. DIST. NO. 282 PRIMARY REG. DIST. NO. 4424 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY Pelk		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Humansville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Osceola (Rural)	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Dimbit Memorial Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) R.	c. (Last) Davis	4. DATE OF DEATH (Month) (Day) (Year) Feb; 24 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb; 8 1885	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MINS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Clair Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Davis	13b. MOTHER'S MAIDEN NAME Fanny Vaughn	14. NAME OF HUSBAND OR WIFE Dollie Davis Collins Mo.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Dollie Davis Collins Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocarditis		INTERVAL BETWEEN ONSET AND DEATH 4 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis		
	DUE TO (c) 4317		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from February 19, 1949, to February 24, 1949, that I last saw the deceased alive on February 24, 1949, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. Robinson	23b. ADDRESS M. H. Osceola Mo	23c. DATE SIGNED 2/24/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb; 28 1949	24c. NAME OF CEMETERY OR CREMATORY Macedonia	24d. LOCATION (City, town, or county) (State) Vista Missouri
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DATE REC'D BY LOCAL REG. Mar. 3, 1949	REGISTRAR'S SIGNATURE Ralph Garden	PER 258	25. FUNERAL DIRECTOR'S SIGNATURE J. B. Goodrich	ADDRESS Osceola Mo
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7

District File Number 249-211

Date Filed 3-9-49

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
Student Embalmer

Signed *F B Goodrich*

Licensed Embalmer No. 3038

P. O. Address *Osceola 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 this body is not embalmed, fact should be so stated above.