

FILED MAR 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7537
Registrar's No. 98

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>		Registrar's No. <u>98</u>	
1. PLACE OF DEATH <u>Poplar Bluff Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>Butler Co.</u>		b. COUNTY <u>Butler</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Butler</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff, 330 N. Main</u>		3	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Poplar Bluff Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>330 North Main.</u>			
3. NAME OF DECEASED (Type or Print) <u>Robert Lee Davis</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March, 11, 49</u>				
a. (First)		b. (Middle)		c. (Last)			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widower</u>		8. DATE OF BIRTH <u>Dec. 3, 1880</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u>		IF UNDER 1 HR. Hour <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fireman</u>		11. BIRTHPLACE (State or foreign country) <u>Butler Co. Poplar, Bluff</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jess Davis</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
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. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Allie Martin, Blytheville Ark.</u>		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>hemorrhage cerebral</u>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) <u>arterio sclerosis general</u>				<u>unknown</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>Hypertension</u>				<u>unknown</u>	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>Sinusitis maxillary bilateral</u>				<u>unknown</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____			
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 _____			
22. I hereby certify that I attended the deceased from <u>2-8</u> , 19 <u>49</u> , to <u>3-11</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>49</u> , and that death occurred at <u>10:40 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>B. Macauley M.D.</u>				23b. ADDRESS <u>Poplar Bluff Mo</u>		23c. DATE SIGNED <u>3-16-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3.12.49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Poplar Bluff Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3/17/49</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Watkins Funeral Service, Dexter Mo.</u>		ADDRESS _____	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

12
7
3

MAR 25 REC'D
Cotler Co. Health Center

349-39
3-25-47

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.

Signed Lynnon Steele

Signed _____
Student Embalmer

Licensed Embalmer No. 2476

P. O. Address Nexter 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.