

FILED APR 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9997

State File No.

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3087 Registrar's No. 35

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| 1. PLACE OF DEATH a. COUNTY St Charles | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Charles | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St Charles) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles | |
| c. LENGTH OF STAY (In this place) 55 yrs | | d. STREET ADDRESS (If rural, give location) 717 Washington | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph Hospital | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Sallie b. (Middle) Annn c. (Last) Davis | 4. DATE OF DEATH Month March Day 24 Year 1950 |
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|----------------------|-------------------------------|---|--------------------------------------|---|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Sept 23 1872 | 9. AGE (In years last birthday) 77 | 10. UNDER 1 YEAR Months 11 Days 11 | 11. UNDER 1 HR. Hours 11 Min. 11 |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Troy Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
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|---------------------------------------|--|--|
| 13a. FATHER'S NAME Mason Frink | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Ambrose Davis |
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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) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Ruby Miller St Charles Mo. |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Insufficiency | | 8 months |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis Heart Disease | | 8 months |
| | DUE TO (c) Arteriosclerosis, General | | years |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 4-600 |

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| 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) (Min.) | 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 4-21, 1947, to 3-24, 1950, that I last saw the deceased alive on 3-23, 1950, and that death occurred at 7:00 a.m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Ruby Miller | 23b. ADDRESS 114 N. Main St. Charles, Mo. | 23c. DATE SIGNED 27 Mar. 50 |
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|---|---------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE March 27, 1950 | 24c. NAME OF CEMETERY OR CREMATORY Oak Grove, Cemetery | 24d. LOCATION (City, town, or county) (State) St Charles Mo. |
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|--|--|--|---------------------------------|
| DATE REC'D BY LOCAL REG. 4-6-50 | REGISTRAR'S SIGNATURE Ruby Miller | 25. FUNERAL DIRECTOR'S SIGNATURE Nachmann | ADDRESS Gene St. Charles |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

7423
0

8723

0

284

MAY 8 1950

District No. 9

District Health Officer No. 9

RECEIVED
APR 10 1950

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 Arthur C. Bane

Licensed Embalmer No. 3125

P. O. Address St Charles 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.