

THE DIVISION OF HEALTH OF MISSOURI
FILED APR 23 1951 STANDARD CERTIFICATE OF DEATH

State File No. 12228

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 320-A

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

1. PLACE OF DEATH a. COUNTY <u>Breene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Battlefield, RURAL</u>	
c. LENGTH OF STAY (In this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>Route # 1 Brookline, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Louisa</u>	b. (Middle)	c. (Last) <u>Davis</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 8, 1951</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 17</u>	9. AGE (In years last birthday) <u>13</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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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>	11. BIRTHPLACE (State or foreign country) <u>Greene Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Robert Yocum</u>	13b. MOTHER'S MAIDEN NAME <u>Margurite Cowells</u>	14. NAME OF HUSBAND OR WIFE <u>Art Davis</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Art Davis</u>	ADDRESS <u>Battlefield, Mo.</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		
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 <u>4500</u>	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)	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 March, 1951, to April, 1951, that I last saw the deceased alive on April 8, 1951, and that death occurred at 1:30pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Harl J. Leidinger Jr. M.D.</u>	(Degree or title)	23b. ADDRESS <u>Republic, Mo.</u>	23c. DATE SIGNED <u>4-12-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/11/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Manley Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Near Springfield, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>4-16-51</u>	REGISTRAR'S SIGNATURE <u>W.E. Handley</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H.H. Lohmeyer</u>	ADDRESS <u>Springfield, Mo.</u>
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MAY 13 1947

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.....

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working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Javier J. Swadby*

Licensed Embalmer No. *4815*

P. O. Address *Springfield*

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.