

FILED AUG 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23434**
Registrar's No. **123**

BIRTH NO. _____ REG. DIST. NO. **155** PRIMARY REG. DIST. NO. **3147**

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Newton	
b. CITY (If outside corporate limits, write RURAL and give township) Webb City		c. CITY (If outside corporate limits, write RURAL and give township) Rural Seneca	
c. LENGTH OF STAY (In this place) 2 Days		d. STREET ADDRESS (If rural, give location) Rt. #2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jane Chinn Hospital			

3. NAME OF DECEASED (Type or Print) Glenda	a. (First)	b. (Middle) Sue	c. (Last) DAVIS	4. DATE OF DEATH (Month) (Day) (Year) July 16, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH July 14, 1951	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. 2
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Harley Davis	13b. MOTHER'S MAIDEN NAME Norma Prevo	14. NAME OF HUSBAND OR WIFE -----
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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. -----	17. INFORMANT'S SIGNATURE OR NAME Harley Davis	ADDRESS Rt. #2 Seneca, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anaphylaxis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Phenylephrine sulfate		
DUE TO (b) -----		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 776 X	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 **July 14, 1951**, to **July 16, 1951**, that I last saw the deceased alive on **July 16, 1951** and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harley Davis	23b. ADDRESS Joplin Mo	23c. DATE SIGNED 7-24-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/18/51	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) (State) Joplin, Missouri
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DATE REC'D BY LOCAL REG. Aug 1-51	REGISTRAR'S SIGNATURE H. J. ...	25. FUNERAL DIRECTOR'S SIGNATURE Thornhill-Dillon Mort	ADDRESS Joplin, Mo.
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RECEIVED 8/7/51
Jasper County Health Office
County File Number 51-8-23
Date Filed 8/8/51

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Charles E. Frey

Signed.....
Student Embalmer

Licensed Embalmer No. 47680

P. O. Address Joplin, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.