

FILED AUG 27 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26731

BIRTH NO.		REG. DIST. NO. 142		PRIMARY REG. DIST. NO. 4251		Registrar's No. 30	
1. PLACE OF DEATH a. COUNTY <b>Howell</b> <i>0460</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>			
b. CITY OR TOWN <b>Mountain View, Mo</b>				c. CITY OR TOWN <b>Mountain View, Mo</b> <i>0460</i>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>None</b>				d. STREET ADDRESS (If rural, give location) <b>0</b>			
3. NAME OF DECEASED (Type or Print) <b>Robert</b>		a. (First) <b>E. Lee</b>		c. (Last) <b>Davis</b>		4. DATE OF DEATH <b>Aug 15th 1951</b>	
5. SEX <b>MO</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 20,</b>		9. AGE (In years last birthday) <b>&amp; 77</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		NAME OF HUSBAND OR WIFE <b>Garrie Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Spanish War</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Garrie Davis</b> ADDRESS <b>Mtn View, Mo</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of bladder</b>				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 <b>181X</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 _____, 1949, to <b>Aug 15, 1951</b> , that I last saw the deceased alive on <b>Aug 15, 1951</b> , and that death occurred at <b>10 Pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Stanley Barman, D.O.</b> (Degree or title)				23b. ADDRESS <b>Mountain View, Mo</b>		23c. DATE SIGNED <b>8-17-51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>aug 17 51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mountain View, Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Mountain View, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>8-17-51</b>		REGISTRAR'S SIGNATURE <b>Loana Mitchell</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Duncan Funeral</b> ADDRESS <b>Home Mtn View, Mo</b>			

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

DIVISION OF HEALTH OF MD.  
District No. 5 - Springfield

RECEIVED AUG 21 1951  
Dist. File 851-1523  
Date Filed 8-22-51

DIVISION OF HEALTH OF MD.  
District No. 5 - Springfield

RECEIVED AUG 21 1951  
Dist. File \_\_\_\_\_  
Date Filed \_\_\_\_\_

**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 John F. Surcom  
Licensed Embalmer No. 2516  
P. O. Address 211 West 4th

**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.