

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12365

State File No.

APR 21 1952

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>	
c. LENGTH OF STAY (In this place) <u>3 mos.</u>		d. STREET ADDRESS (If rural, give location) <u>211 E. Excelsior St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>211 E. Excelsior St.</u>		e. STREET ADDRESS (If rural, give location) <u>211 E. Excelsior St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>B.</u> c. (Last) <u>DAVIS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 15, 1952</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 18, 1864</u>	9. AGE (In years last birthday) <u>88</u>	10. IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>George Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Jane Boring</u>	14. NAME OF HUSBAND OR WIFE <u>Penner Cathern Riley</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. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. R.G. Lawrence, Ex. Springs, Mo.</u>	ADDRESS _____
--	--	---	---------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemiplegia</u>		
	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 <u>334X</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) _____	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 Dec. 30, 1951, to Mar. 15, 1952, that I last saw the deceased alive on Mar. 15, 1952, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>George R. Lawrence, D.O.</u> (Degree or title)	23b. ADDRESS <u>Excelsior Springs, Mo.</u>	23c. DATE SIGNED <u>3-16-52</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3-16-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wilsontown Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kirksville, Missouri</u>
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. <u>3/16/52</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Richard</u>	ADDRESS <u>Excelsior Springs, Mo.</u>
---	---	---	---------------------------------------

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

242

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 Lindell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.