S. No. 300
v. 10-48

FILED AUG 17 1953

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

28286

State File No. DR WHITE

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 760

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

**1. PLACE OF DEATH**
a. COUNTY: GREENE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SPRINGFIELD
c. LENGTH OF STAY (in this place): 20 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BURGE HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: GREENE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SPRINGFIELD
d. STREET ADDRESS (If rural, give location): 911 EAST MADISON

0396
0

**3. NAME OF DECEASED** (Type or Print)
a. (First): ETHEL
b. (Middle): WALKER
c. (Last): DAVIDSON

**4. DATE OF DEATH** (Month) (Day) (Year): AUG, 11, 1953

**5. SEX**: FEMALE
**6. COLOR OR RACE**: WHITE
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED
**8. DATE OF BIRTH**: APRIL, 20, 1892
**9. AGE** (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE & DR OF CHIROPRACTOR
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (State or foreign country): MISSOURI
**12. CITIZEN OF WHAT COUNTRY?**: U. S. A

**13a. FATHER'S NAME**: JOHN W. WALKER
**13b. MOTHER'S MAIDEN NAME**: MARY TURNER
**14. NAME OF HUSBAND OR WIFE**: REGINAL DAVIDSON

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): NO — (If yes, give war or dates of service): No
**16. SOCIAL SECURITY NO.**: UNKNOWN
**17. INFORMANT'S SIGNATURE OR NAME**: DR REGINAL DAVIDSON — ADDRESS: SPRINGFIELD, MO

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Carcinoma Rt Breast — 2 years
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**: 170 X
**20. AUTOPSY?** YES ☐ NO ☒

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Nov, 1952, *to* Aug 11, 1953, *that I last saw the deceased alive on* Aug 11, 1953, *and that death occurred at* 12:15A m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): R Redwhite MD
**23b. ADDRESS**: 609 Cherry Springfield
**23c. DATE SIGNED**: 11 Aug 53

**24a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**24b. DATE**: 8/13/53
**24c. NAME OF CEMETERY OR CREMATORY**: EASTLAWN
**24d. LOCATION** (City, town, or county) (State): SPRINGFIELD, MISSOURI

**DATE REC'D BY LOCAL REG.**: 8-11-53
**REGISTRAR'S SIGNATURE**: Edith Williamson
**25. FUNERAL DIRECTOR'S SIGNATURE**: HERMAN LOHMEYER — ADDRESS: SPRINGFIELD, MO

(Licensed Embalmer's Statement on Reverse Side)

## 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 Bert Lohmeyer

Licensed Embalmer No. 4734

P. O. Address Spfd, 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.