

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1084

State File No. ....

FILED JAN 25 1954

BIRTH NO. ....

REG. DIST. NO. 137

PRIMARY REG. DIST. NO. 3023

Registrar's No. 290

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY OR TOWN <u>Clinton</u>		c. CITY OR TOWN <u>Miami</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>12 days</u>		e. STREET ADDRESS (If rural, give location) <u>General Delivery 1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clinton General Hosp.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CORA</u>		b. (Middle) <u>BELLE</u>	c. (Last) <u>DAVIS</u>
4. DATE OF DEATH (Month) (Day) (Year) <u>1-18-1954</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Feb. 10, 1869</u>
9. AGE (in years last birthday) <u>84</u>	10. MONTH <u>11</u>	11. DAY <u>8</u>	12. HOUR <u>-</u> MIN. <u>-</u>
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>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Saline County Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>J. B. Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ellen Williamson</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (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>Mrs. Joe Ross</u> ADDRESS <u>Blairtown Mo</u>
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchial asthma</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	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) m.		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 <u>1-6</u> , 19 <u>54</u> , to <u>1-18</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>54</u> , and that death occurred at <u>2 P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>H. Walker M.D.</u>		23b. ADDRESS <u>Clinton Mo</u>	23c. DATE SIGNED <u>1-19-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1/20/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Miami</u>	24d. LOCATION (City, town, or county) (State) <u>Miami Mo</u>
DATE REC'D BY LOCAL REG. <u>Jan-20-54</u>		REGISTRAR'S SIGNATURE <u>Florence Adams</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Fred Wilkinson</u> ADDRESS <u>Funeral Home</u>

(Licensed Embalmer's Statement on Reverse Side) (Clinton Mo)

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

FEB 16 1954

### 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 \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 431

P. O. Address \_\_\_\_\_  
Clinton Dr

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.