

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7517**

BIRTH NO. **FILED MAR 4 1954** REG. DIST. NO. **347** PRIMARY REG. DIST. NO. **6658** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY Stone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stone	
b. CITY OR TOWN Blue Eye		c. CITY OR TOWN Blue Eye	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1 Mile N. of Blue Eye		d. STREET ADDRESS (If rural, give location) 1 Mile N. of Blue Eye	

3. NAME OF DECEASED (Type or Print) WILLIAM M DAVIS			4. DATE OF DEATH Feb. 23 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 2 April 1857		9. AGE (In years last birthday) 96		IF UNDER 1 YEAR: 10 Months 21 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co. Arkansas
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Jeff Davis		13b. MOTHER'S MAIDEN NAME Kathryn Standlee		14. NAME OF HUSBAND OR WIFE Mary Sneed Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME W. L. Davis - Oak Grove, Ark.	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND 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. Fractured Hip			
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 **Feb 22, 1954**, to **Feb 22, 1954**, that I last saw the deceased alive on **Feb 22, 1954**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE James S. Paddy M.D. (Degree or title)		23b. ADDRESS Berryville Ark.		23c. DATE SIGNED 2/25/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-25-54		24c. NAME OF CEMETERY OR CREMATORY Berryville Mem. Park Berryville, Ark.	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG. Feb 26 - 54		REGISTRAR'S SIGNATURE Mrs J. Emma Br... 317-0		25. FUNERAL DIRECTOR'S SIGNATURE Nelson Funeral Home - Berryville, Ark	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Charles M. Wilson

Licensed Embalmer No. 815 Ark

P. O. Address Beryville, Ark

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.