

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7586

State File No. ....

BIRTH NO. FILED MAR 8 1954 REG. DIST. NO. 373 PRIMARY REG. DIST. NO. 62.67 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>EAHLAND MO</b>		c. CITY OR TOWN <b>EAHLAND MO</b>	
c. LENGTH OF STAY (in this place) <b>28 yrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <b>1120</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>NORA</b> b. (Middle) <b>ALICE</b> c. (Last) <b>DAVISON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>FEB 25 1954</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV 27 1901</b>	9. AGE (In years last birthday) <b>52</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>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>FAIR GROVE MO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>HARRISON NICHOLS</b>		13b. MOTHER'S MAIDEN NAME <b>NETTIE COWER DOLON</b>	
14. NAME OF HUSBAND OR WIFE <b>DAVISON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>DOLON DAVISON</b>		ADDRESS <b>EAHLAND MO</b>			

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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremia</b>		DUPLICATE OF (b) <b>Metastatic Carcinoma of 8-12 mo</b>				<b>1 wk</b>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUPLICATE OF (c) <b>Carcinoma of Uterus</b>				<b>2-3 yr</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Malignant Hypertension</b>				<b>7-8 yrs</b>	
19a. DATE OF OPERATION <b>6-30-53</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Uterus</b>				174 X	
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **May 18 1953**, to **18 Feb 1954**, that I last saw the deceased alive on **2-25 1954**, and that death occurred at **8:30 A.M.**, from the causes and on the date stated above:

23a. SIGNATURE <b>O. Gruffin</b>		(Degree or title) <b>MD</b>		23b. ADDRESS <b>Buffalo Mo</b>		23c. DATE SIGNED <b>1 March 54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>2-28-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT VIEW</b>		24d. LOCATION (City, town, or county) (State) <b>WEBSTER CO MO</b>	
DATE REC'D BY LOCAL REG. <b>3-2-54</b>		REGISTRAR'S SIGNATURE <b>L. Francis</b>		392- <b>BARBER-BARTO</b>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>MARSHFIELD</b>	

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.....  
Signature of Student Embalmer

Signed *Glen S. Williams*

Licensed Embalmer No. *462*

P. O. Address *Marshfield*

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.