

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11239**

No. 300
10.48

FILED MAY 3 1954

REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **437**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL R.F.D. 1 Fillmore	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		d. STREET ADDRESS (If rural, give location) 2 mi. East Fillmore	
3. NAME OF DECEASED a. (First) IDA b. (Middle) MAY c. (Last) DAVISON			4. DATE OF DEATH (Month) (Day) (Year) 4-27-1954
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9-6-1876
9. AGE (In years last birthday) 77	10. MONTHS 7	10. DAY 22	9. AGE (In years last birthday) 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) Council Bluffs IOWA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Silas Elberts	
13b. MOTHER'S MAIDEN NAME MARY Williams		13c. NAME OF HUSBAND OR WIFE FRANK DAVISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Jack Davison ADDRESS R.F.D. Fillmore 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ulcer of the Stomach ANTECEDENT CAUSES mostly hemorrhage DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Rupture of the Ulcer II. OTHER SIGNIFICANT CONDITIONS Calcium Sarcoidosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None performed	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (Home, farm, factory, street, or bldg., etc.) at home	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) Fillmore Andrew MO	
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 4-22, 1954 to 4-27, 1954 ; that I last saw the deceased alive on 4-27, 1954 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ralph P. Miller M.D.		23b. ADDRESS Savannah MO	23c. DATE SIGNED 4-29-54
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-30-1954	24c. NAME OF CEMETERY OR CREMATORY Fillmore	24d. LOCATION (City, town, or county) (State) Fillmore MO
DATE REC'D BY LOCAL REG. April 29, 1954	REGISTRAR'S SIGNATURE Arthur M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Breit Funeral Home ADDRESS SAVANNAH MO	

(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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Ga

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.