

No. 300
10-48

23051

FILED AUG 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 193

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. 4372 Registrar's No. 193

1. PLACE OF DEATH a. COUNTY NODAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY NODAWAY	
b. CITY OR TOWN BURLINGTON JCT	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN BURLINGTON JCT	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME		e. STREET ADDRESS (If rural, give location) 0770	

3. NAME OF DECEASED (Type or Print) a. (First) BESSIE b. (Middle) PEARL c. (Last) DAVISON			4. DATE OF DEATH (Month) (Day) (Year) JULY 22 1955		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 31, 1877	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 6 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Mo	
12. CITIZEN OF WHAT COUNTRY U.S.					

13a. FATHER'S NAME WILLIAM F. CURBERTSON		13b. MOTHER'S MAIDEN NAME Mrs. EUGENIA CARMICHAEL		14. NAME OF HUSBAND OR WIFE LAWRENCE DAVISON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME LAWRENCE DAVISON ADDRESS BURLINGTON JCT 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) Carcinoma of Breast ANTECEDENT CAUSES Metastasis cerebral Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 170X			INTERVAL BETWEEN ONSET AND DEATH 6-12 hrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerosis					
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) (Min)		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**, 19**52**, to **July 21**, 19**55**, that I last saw the deceased alive on **July 21**, 19**55**, and that death occurred at **4:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE B. K. Empe (Degree or title) MD		23b. ADDRESS Wm. G. Mainville M.D.		23c. DATE SIGNED 7-30-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 25, 1955	24c. NAME OF CEMETERY OR CREMATORY Oak Grove	24d. LOCATION (City, town, or county) (State) CHARLTON IOWA		
DATE REC'D BY LOCAL REG. 8-6-55		REGISTRAR'S SIGNATURE Bess Holt		FUNERAL DIRECTOR'S SIGNATURE J. H. ... ADDRESS Burl Jct Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

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