

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28277

FILED AUG 24 1956

318

1003

STATE FILE NUMBER

6497

Registration District No. Primary Registration District No. Registrar's No.

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ripley</u>			
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Doniphan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Baptist Hospital</u>				Length of stay in 1b <u>1 wk.</u>		d. STREET ADDRESS (If outside, give location) <u>Box 73</u>	
3. NAME OF DECEASED (Type or print) First <u>Bryan</u> Middle Last <u>Davidson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1900</u>		9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>9</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationary</u>		11. BIRTHPLACE (City and state or country) <u>Cameron, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Davidson</u>				14. MOTHER'S MAIDEN NAME <u>Edna Spinks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Mrs. Velma Davidson, Doniphan, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>T. trigeminal neuralgia</u> <u>Cardiac infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u> <u>1 1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>--</u>				
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>420.1</u>		20g. COUNTY STATE		
21. I attended the deceased from <u>7-7-56</u> to <u>7-10-56</u> and last saw ^{him} her alive on <u>7-10-56</u> Death occurred at <u>6:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <u>Robert H. Hoppe M.D.</u>				22b. ADDRESS <u>6944 Chippewa</u>		22c. DATE SIGNED <u>7-11-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-11-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cameron, Texas</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Stanley H. Dipo*.....

Licensed Embalmer No. *41*.....

P. O. Address *St. L.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.