

FILED JAN 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 40751

Registration District No. 43 Primary Registration District No. 4056 Registrar's No. 75

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fisk		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fisk Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home- Fisk, Mo.		Length of stay in lb 6 Yrs.	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JAMES Middle F. Last DAVIS			4. DATE OF DEATH Month Dec. Day 26 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12 1875	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 0 Days 14 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ike Davis		14. MOTHER'S MAIDEN NAME Unknown	
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 Ellen Davis Fisk Missouri

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy			INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertension			10 yrs.
	DUE TO (c) Arteriosclerosis			15 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 334x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from **20 Dec 56** to **26 Dec 56** and last saw her alive on **24 Dec 56**
Death occurred at **9:30 A.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Cynthia - Ret m D	22b. ADDRESS Poplar Bluff, Mo	22c. DATE SIGNED 27 Dec 56
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 28 1956	23c. NAME OF CEMETERY OR CREMATORY Browns Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Broseley Missouri
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24. FUNERAL DIRECTOR Landess Funeral Home	ADDRESS Campbell, Mo.	25. DATE RECD. BY LOCAL REG. 4-1-57	26. REGISTRAR'S SIGNATURE R D Mustice
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Services
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1-56
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

RECEIVED
JAN 7 - 1957

BUTLER CO. HEALTH CENTER

FILE No. _____

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 *Christina M. Lande* _____

Licensed Embalmer No. *422*

P. O. Address *Camp* _____

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