

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8257

STATE FILE NUMBER

FILED APR 1 - 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 272

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital Length of stay in lb 50 Yrs.		d. STREET ADDRESS (If outside, give location) 920 W. Harrison Reside on Form <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MICAH Middle JANE Last DAVISON			4. DATE OF DEATH Month March Day 22 Year 1957		
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5. SEX Female	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 29 Aug. 1878	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME William E. Case	14. MOTHER'S MAIDEN NAME Sarah Hannah
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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. No	17. INFORMANT Hospital Records Address _____
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis Generalized	
	DUE TO (c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) —		19. WAS AUTOPSY PERFORMED? 2 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.) —
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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 _____
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21. I attended the deceased from 11 June 1952 to 22 March 57 and last saw her ^{her} ~~him~~ alive on 22 March 57
Death occurred at 9:10 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Charles A. Peterson M.D.</i> (Degree or title)	22b. ADDRESS 1211 S. Glenstone Springfield, Missouri	22c. DATE SIGNED 25 March 57
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23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	23b. DATE 3-24-57	23c. NAME OF CEMETERY OR CREMATORY Timber Ridge	23d. LOCATION (City, town, or county) (State) Webster Co. Mo.
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24. FUNERAL DIRECTOR J.W. Klingner & Co. ADDRESS Spgrfd. Mo.	25. DATE RECD. BY LOCAL REG. 3-26-57	26. REGISTRAR'S SIGNATURE <i>Edith Williamson</i>
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(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs are to be recorded.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Max Rhodes*

Licensed Embalmer No. 4

P. O. Address *Perth Amboy, N.J.*

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.