

FILED JUN 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18367

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 158

300
1-56

All diseases in Part I must be causally related. Carcener cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

1. PLACE OF DEATH a. COUNTY <u>St. Francis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Flat River</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Flat River</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>223 Rider</u> Length of stay in 1b <u>1 year</u>		d. STREET ADDRESS (If outside, give location) <u>223 Rider</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Franklin Davis</u> First Middle Last		4. DATE OF DEATH <u>May 24 1957</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3 1884</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Sheardon Wyoming</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Davis</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</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>4200</u>		17. INFORMANT <u>Mary Bone St. Louis Mo.</u> Address	
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>arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>acute Gastro intestinal</u> DUE TO (c) <u>Unmyelized arterial sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>2 weeks</u> <u>Several years</u>
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 <u>5/22/57</u> to <u>5-22-57</u> and last saw ^{her} _{him} alive on <u>5/22/57</u> Death occurred at <u>5/24/57 7:30A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Karl L. Jones MD</u>		22b. ADDRESS <u>Flat River Mo</u>	
22c. DATE SIGNED <u>5/27/57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>5-26-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Higgins Cem.</u>	
23d. LOCATION (City, town, or county) <u>Washington Co. Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Murphy L. Sparks, Flat River, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>May 31 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Ether Ruddleff</u>			

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 *Murphy L. Sparks*.....

Licensed Embalmer No. *42*.....

P. O. Address *Flat 12*.....

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.