

Health, Welfare, Public Service

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED AUG 5 1957

Registration District No. 359 Primary Registration District No. 6217 Registrar's No. 10

300 1

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rural Badger sp.</u> | | c. CITY OR TOWN <u>Oleessa</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) <u>Year Walker no</u> | | d. STREET ADDRESS (If outside, give location) <u>Rural</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Davis</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u> | |
| 5. SEX <u>Female</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>Oct. 12 - 1977</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years less than day) <u>79</u> Months <u>9</u> Days <u>9</u> |
| 11. BIRTHPLACE (City and state or country) <u>Higginsville, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>John Haring</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sue</u> | 14. NAME OF HUSBAND OR WIFE <u>James M. Davis "deceased"</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. | 17. INFORMANT <u>Joseph H. Davis Walker, Mo</u> Son Address <u>P. 7 D.</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>Cerebral hemorrhage - R. Hemiplegia</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>Don't know duration</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Advanced age</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <u>no</u> | | 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 _____ 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 <u>Nevada</u> | COUNTY <u>Vernon</u> |
| 21. I attended the deceased from <u>July 15</u> to <u>July 21</u> and last saw her alive on <u>July 21 - 57</u> . Death occurred at <u>2:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | STATE <u>Mo.</u> | |
| 22a. SIGNATURE <u>W. Love, MD</u> (Degree or title) | | 22b. ADDRESS <u>Nevada, Mo</u> | 22c. DATE SIGNED <u>7/23/57</u> |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE <u>7-21-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Local Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Oleessa, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Days Funeral Service, Inc</u> <u>Nevada, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>July 30 - 57</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Ruth Faith</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

30

0

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 *H. H. Marmaduke*

Licensed Embalmer No. *2070*

P. O. Address *Meads, Mo*

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