

Health,
& Welfare
S. Public
th Service

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

389889
STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 6269 Registrar's No. 42

S. 300
v. 1-57

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1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>E OZARK</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>MARSHFIELD MO R3</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>4 MI EAST</u>

3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>DAVIS</u> Middle Last			4. DATE OF DEATH <u>OCT 11 1957</u> Month Day Year		
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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>OCT 1 1877</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days	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) <u>RET FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>CHARLIE DAVIS</u>	13b. MOTHER'S MAIDEN NAME <u>MINERVA YATES</u>	14. NAME OF HUSBAND OR WIFE <u>ROSA</u>
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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>ROSA DAVIS MARSHFIELD MO R3</u>	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) <u>Shock - Severe Secondary Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>38 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hemorrhage, Intestinal</u>	<u>4 days</u>
	DUE TO (c) <u>Unknown - Possible Carcinoma of Stomach</u>	<u>1 1/2 yrs.</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Bronchitis, Congestive Heart Disease, Psoriasis</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.)
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20c. TIME OF INJURY Hour 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 <u>May 28, 1957</u> to <u>Oct. 11, 1957</u> and last saw him alive on <u>Oct. 10, 1957</u> Death occurred at <u>900 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>J. M. Macdonnell MD</u> (Degree or title)	22b. ADDRESS <u>Marshfield, Mo.</u>	22c. DATE SIGNED <u>19 Oct 57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-14-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GOOD HOPE</u>	23d. LOCATION (City, town, or county) (State) <u>WEBSTER CO MO</u>
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24. FUNERAL DIRECTOR <u>BARBER-EDWARDS MARSHFIELD</u>	25. DATE RECD. BY LOCAL REG. <u>10/24/57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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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 *George Stoff*

Licensed Embalmer No. *3/01*

P. O. Address *1211 Broadway*

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.