

Health,  
Welfare  
Public  
Service

Dr. Webb

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013818  
STATE FILE NUMBER

FILED MAY 5 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 4338

300  
-57

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1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> <i>0396</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. ST. JOHN'S HOSP.</b>		Length of stay in lb <b>50 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>2449 N. GLENSTONE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ETHEL MAE DAVIS</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1958</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 24 1908</b>		9. AGE (In years last birthday) <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO. 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>JAMES WRIGHT</b>		13b. MOTHER'S MAIDEN NAME <b>ALICE GILMORE</b>		14. NAME OF HUSBAND OR WIFE <b>HILLIS DAVIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>HILLIS DAVIS</b> Address <b>SPRINGFIELD, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary aspiration of food</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Laryngeal spasm</b>					<b>5 min.</b>
DUE TO (c) <b>Unknown cause</b>					<b>517X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>May, 1957</b> to <b>April 21, 1958</b> and last saw her alive on <b>April 21, 1958</b> Death occurred at <b>2 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>L. Richard Webb, M.D.</b>			22b. ADDRESS <b>609 Cherry St., Springfield, Mo.</b>		22c. DATE SIGNED <b>4/25/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>
24. FUNERAL DIRECTOR <b>H. H. LOHMEYER</b>		ADDRESS <b>SPRINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4/28/58</b>	26. REGISTRAR'S SIGNATURE

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Gene Lohoney* .....

Licensed Embalmer No. *4734* .....

P. O. Address *Appl. 9* .....

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.