

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013819  
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 391

1. PLACE OF DEATH a. COUNTY <u>GREENE</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>SPRINGFIELD</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MARSHFIELD R3</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE Hosp/6 DAYS</u>		Length of stay in lb <u>6 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>4 MI EAST</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last <u>ROSA LEE DAVIS</u>			4. DATE OF DEATH Month Day Year <u>APR 10 1958</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>SEPT 11 1882</u>
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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	11. BIRTHPLACE (City and state or country) <u>MISSOURI 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>CHARLES CASTEE</u>	
13b. MOTHER'S MAIDEN NAME <u>MARY EVANS</u>		14. NAME OF HUSBAND OR WIFE	
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 Address <u>IRA CASTEE MARSHFIELD</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>Pulmonary Embolus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of Bladder</u> DUE TO (c) <u>1810</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 yr?</u>
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 type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 <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>3-25-58</u> to <u>4-10-58</u> and last saw her alive on <u>4-10-58</u> Death occurred at <u>11:05 A. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or informant) <u>William F. Johnson M.D.</u>		22b. ADDRESS <u>211 Prof. Bldg., Springfield</u>	22c. DATE SIGNED <u>4-14-58</u>
23a. BURIAL, CREMATION, EMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GOOD HOPE</u>	23d. LOCATION (City, town, county) (State) <u>WEBSTER CO MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>BARBER EDWARDS MARSHFIELD</u>		25. DATE RECD. BY LOCAL REG. <u>4-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300 0  
1-57

**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 Stapp* .....

Licensed Embalmer No. *3161* .....  
P. O. Address *Mt. Laurel, 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.