

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021115

STATE FILE NUMBER

FILED JUL 10 1958

Registration District No.

43

Primary Registration District No.

5138

Registrar's No.

426

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Butler</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Butler</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ellsinore</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Ellsinore</b> 0120		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R R # 1</b>		Length of stay in 1b <b>Life</b>	d. STREET ADDRESS (If outside, give location) <b>R R # 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Jane Davis</b>			4. DATE OF DEATH Month Day Year <b>6-26-1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-26-1923</b>		9. AGE (In years last birthday) <b>35</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Ellsinore, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Fred Davis</b>		13b. MOTHER'S MAIDEN NAME <b>Dovie Roark</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Dovie Davis, Ellsinore, 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>Chronic Myocardial Degeneration</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Malnutrition</b>				<b>20 yrs.</b>	
DUE TO (c) <b>Cerebral Palsy and Epilepsy</b>				<b>30 yrs.</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 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 <b>June 15, 1958</b> to <b>June 26, 1958</b> and last saw her/him alive on <b>June 22, 1958</b> Death occurred at <b>3:30 a. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Henry R. Rosy</b>			22b. ADDRESS <b>2 D.O. Van Buren, Missouri</b>		22c. DATE SIGNED <b>6-30-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-28-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Wayne County, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Grøer Croy &amp; Fitch, Poplar Bluff, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>7/5/58</b>		26. REGISTRAR'S SIGNATURE <b>R. H. Metree</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

RECEIVED  
JUL 8 1958

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 Ray J. Adams  
Licensed Embalmer No. 4928  
P. O. Address Poplar Bluff

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.