

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002262
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 231 Primary Registration District No. 3048 Registrar's No. 24

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1-57

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maryville		c. CITY OR TOWN Maryville 0742	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Francis Hospital		d. STREET ADDRESS (If outside, give location) 341 E 1st	
3. NAME OF DECEASED (Type or print) Laura Belle Davis		4. DATE OF DEATH Month 2 Day 1 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1869
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		9b. KIND OF BUSINESS OR INDUSTRY home-own	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (City and state or country) Hagerstown, Indiana	
13a. FATHER'S NAME Joseph Smith		13b. MOTHER'S MAIDEN NAME Miriam Schildknecht	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Everett Davis, Maryville, Mo.		14. NAME OF HUSBAND OR WIFE Dwight Davis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of hip Nov 1958 42211			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 <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 Nov 1958 to Feb 1, 1959 and last saw her alive on Feb 1, 1959 Death occurred at 10 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. E. Embelmer M.D.		22b. ADDRESS Maryville Mo	
22c. DATE SIGNED Feb 3, 1959			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2-4-59	
23c. NAME OF CEMETERY OR CREMATORY Bethany		23d. LOCATION (City, town, or county) (State) RR - Barnard, Mo	
24. FUNERAL DIRECTOR Maryville, Mo.		25. DATE RECD. BY LOCAL REG. 2-3-59	
		26. REGISTRAR'S SIGNATURE Bess Holt	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. 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 G M Chelius

Licensed Embalmer No. 2279

P. O. Address Wayne

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.