

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002853  
STATE FILE NUMBER

10 FEB 11 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 358

300  
1-57  
1  
32  
6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lemay 4860
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Brothers Hosp.		Length of stay in 1b 4 Weeks	d. STREET ADDRESS (If outside, give location) 122 a Lemay Ferry Rd.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Earl J. Davis			4. DATE OF DEATH Month Day Year January 10 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 2, 1903	9. AGE (In years last birthday) 55	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) Dispatcher	10b. KIND OF BUSINESS OR INDUSTRY Mississippi River Fuel Corp	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James Davis	13b. MOTHER'S MAIDEN NAME Ollie Laxon	14. NAME OF HUSBAND OR WIFE Ruth
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no., or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unk	17. INFORMANT Mrs. Ollie Holcomb	Address Keifer, Okla.
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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) <i>Severe Pulmonary Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i> <i>Several Wks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Empyema of Rt chest</i>	
	DUE TO (c) <i>Excision of Ca of Rt lung + abscess of lung</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>163X</i>		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
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21. I attended the deceased from 10-1-58 to 1-10-59 and last saw him alive on 1-10-59  
Death occurred at 8:25 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Ernie D. Reelies MD</i>	(Degree or title)	22b. ADDRESS <i>752 Lemay Ferry Rd</i>	22c. DATE SIGNED <i>1.12.59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	Jan. 12, 1959	South Heights Cemetery	Sapulpa, Oklahoma

24. FUNERAL DIRECTOR C. Holmeister Mortuaries 7814 S. Broadway	ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 12 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
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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 *Lewis E. Hoffmeyer* .....

Licensed Embalmer No. *3871* .....

P. O. Address *7814 S. Broad* .....

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.