

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020196

STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 84

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASINGTON TWP Nevada</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u>		Length of stay in 1b <u>2 yrs 4 mos.</u>	d. STREET ADDRESS (If outside, give location) <u>1404 East Elm</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>G.</u> Last <u>Davis</u>			4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1912</u>		9. AGE (In years last birthday) <u>47</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Appliance Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Holleyville, Oklahoma</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>William I. Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Belle Gould</u>	
14. NAME OF HUSBAND OR WIFE <u>Margaret Davis</u>		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. <u>191-03-9875</u>	
17. INFORMANT <u>Records</u>		Address <u>State Hospital #3, Nevada, Mo.</u>		18. CAUSE OF DEATH (Give only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Acute Brain Syndrome Associated with Trauma (Fractured Skull)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201F</u>	
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 _____ 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 <u>November 8, 1956</u> to <u>May 19, 1959</u> and last saw him alive on <u>May 19, 1959</u> Death occurred at <u>11:20</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>George Eskes M.D.</u>		22b. ADDRESS <u>State Hospital #3, Nevada, Mo.</u>		22c. DATE SIGNED <u>5-19-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>May 19, 59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Springfield, Missouri</u>		23e. FUNERAL DIRECTOR <u>Herman Lohmeyer Springfield, Mo.</u>		23f. ADDRESS	
24. FUNERAL DIRECTOR		25. DATE RECD. BY LOCAL REG. <u>5-22-1959</u>		26. REGISTRAR'S SIGNATURE <u>Anna J. Jurek</u>	

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAY 27 1969

FEB 3 1967

MAY 28 1969

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 *Rexy F. Milster*

Licensed Embalmer No. *4825*

P. O. Address *Nebraska, 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.