

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024619

FILED VS AUG 1 0 1959 *98*

Registration District No. _____ Primary Registration District No. _____ Registrar's No. *66*

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Daviess</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Daviess</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Sheridan Twp.</i>	Length of stay in 1b <i>10 years</i>	c. CITY OR TOWN <i>Sheridan Twp</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4 1/2 miles N.E. of Kidder</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>4 1/2 miles NE of Kidder</i>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Linnie</i> Middle <i>May</i> Last <i>Davis</i>			4. DATE OF DEATH Month <i>July</i> Day <i>22</i> Year <i>1959</i>	
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>9-17-1893</i>	9. AGE (last birthday) <i>75</i>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR. Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Ludlow, Missouri</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
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13a. FATHER'S NAME <i>Lewis Warner</i>	13b. MOTHER'S MAIDEN NAME <i>Sarah Achentach</i>	14. NAME OF HUSBAND OR WIFE <i>Harvey A. Davis</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>493-42-4853</i>	17. INFORMANT Address <i>Everett Davis - Kidder, Mo</i>
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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>Myocardial Infarction</i> DUE TO (b) <i>Hypertensive cardiovascular disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year	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 *1956* to *July 1959* and last saw ^{her}him alive on *July 4, 1959*
 Death occurred at *three* *A.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Howard Carter M.D.</i>	22b. ADDRESS <i>Hamilton, Mo</i>	22c. DATE SIGNED <i>July 24, 1959</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>7-24-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Blue Mound</i>	23d. LOCATION (City, town, or county) (State) <i>Blue Mound, Mo.</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Etton Norman - Chillicothe, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>31 July 1959</i>	26. REGISTRAR'S SIGNATURE <i>Viggo M. Engelbert</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elton T. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.