

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024748

FILED VS AUG 3 1959

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 797 A STATE FILE NUMBER

|   |  |   |  |  |   |  |   |
|---|--|---|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> COUNTY <u>Greene</u> |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Springfield</u>   |  | Length of stay in 1b<br><u>17 yrs.</u>  |  | c. CITY OR TOWN <u>Springfield</u>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Shofld. Baptist Hosp.</u>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>Route 8</u>  |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Lee</u> Middle <u>Roy</u> Last <u>Davis</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>25</u> Year <u>1959</u>   |   |  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>       | 7. Married <input checked="" type="checkbox"/> <del>Never Married</del><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11-18-1902</u>  | 9. AGE (last birthday)<br><u>56</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Construction worker</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Construction</u>                             |  | 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>               |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>  |
| 13a. FATHER'S NAME<br><u>John Franklin Davis</u>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Elzora Martin</u>                                    |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Bulah Davis</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>487-24-1527</u>   |  | 17. INFORMANT<br>Address <u>Bulah Davis--Springfield, Mo.</u>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pseudo-membranous Enterocolitis</u>  |  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u>                                    |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Staphylococcus aureus</u>   |  |   |  |  |   |  | <u>10 days</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)<br><u>Acute + Chronic Cholelithiasis with Cholelithiasis</u>  |  |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>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   |
| 21. I attended the deceased from <u>7-6-59</u> to <u>7-25-59</u> and last saw her/him alive on <u>7-25-59</u><br>Death occurred at <u>10:45 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |  |   |
| 22a. SIGNATURE<br><u>Melton</u> (Degree or title) <u>M.D.</u>   |  |   |  | 22b. ADDRESS<br><u>Springfield Mo</u>  |   | 22c. DATE SIGNED<br><u>7-30-59</u> (State)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>7-27-1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Shady Cemetery</u>                          |  | 23d. LOCATION (City, town, or county)<br><u>near Grove Spring, Missouri</u> |  |   |
| 24. FUNERAL DIRECTOR<br><u>Rex Rainey--Springfield, Mo.</u> ADDRESS   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>7-31-59</u>   |   | 26. REGISTRAR'S SIGNATURE<br><u>Effie S. Melton</u>  |   |

DOCUMENT

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

AUG 6 1959

VS SEP 8 1959

*[Handwritten signature]*

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *[Signature]*  
Licensed Embalmer No. 3312

P. O. Address Springfield,

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