

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025923

FILED VS JUL 22 1959

INDEXED

Registration District No. 227 Primary Registration District No. \_\_\_\_\_ Registrar's No. 18

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Maries</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Maries</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Belle</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Belle</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>Home</u>				d. STREET ADDRESS (If outside, give location) <u>Home</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel C. Travis</u>				4. DATE OF DEATH Month <u>7</u> Day <u>6</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>12/21/1873</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant, Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Steen Prarie Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas L. Travis</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Rogers</u>		14. NAME OF HUSBAND OR WIFE <u>Gillie Ann Travis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-09-2402</u>		17. INFORMANT <u>H. O. Travis Belle Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>Cerebral Accident</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Advanced Age</u>						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.)			
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 _____	
21. I attended the deceased from _____ to <u>7/6/59</u> and last saw him alive on _____ Death occurred at <u>8:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Wm. F. ...</u> (Degree or title)				22b. ADDRESS <u>Bland, Mo</u>		22c. DATE SIGNED <u>7/7/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/8/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>NEAR BELLE MO</u>	
24. LOCAL DIRECTOR <u>Chas. L. Jones Belle Mo</u>		ADDRESS		25. DATE REGD. BY LOCAL REG. <u>July 8 - 59</u>		26. REGISTRAR'S SIGNATURE <u>Myrtle Hutchinson</u>	

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*Ormer H. Jones*

Licensed Embalmer No.

*4411*

P. O. Address

*Belle Meade*

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.