

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 24 1959

59-026127

STATE FILE NUMBER

Registration District No. 273 Primary Registration District No. 3057 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>Perry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Genevieve</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Perryville Mo</u>		Length of stay in 1b <u>48 hrs</u>		c. CITY OR TOWN <u>St. Genevieve</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) <u>Perry Co Memorial Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>St. Genevieve</u>	
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>DALE</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>20</u> Year <u>1959</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 3 1956</u>		9. AGE (last birthday) <u>2 yrs</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Perryville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Davis</u>			13b. MOTHER'S MAIDEN NAME <u>Lillian Bacchig</u>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Lillian Davis</u> Address <u>St. Gen, 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>Menigitis, Bacterian</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>Anemia</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 <u>BIRTH NOV 3, 1956</u> to <u>6-19-59</u> and last saw him alive on <u>6-19-59</u> Death occurred at <u>11:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>G. H. De Genova MD</u> (Degree or title)				22b. ADDRESS <u>St. Genevieve, Mo</u>		22c. DATE SIGNED <u>6-20-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-22-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) (State) <u>St. Genevieve, Mo</u>	
24. FUNERAL DIRECTOR <u>James H. Stanton</u> Address <u>St. Genevieve Mo</u>				25. DATE RECD. BY LOCAL REG. <u>6-22-59</u>		26. REGISTRAR'S SIGNATURE <u>Joseph Gollman</u>	

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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

or by James L. Sauter Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James L. Sauter

Licensed Embalmer No. 3817

P. O. Address St. Louis, Mo.

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