

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028503

FILED VS SEP 14 1959

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 253

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Length of stay in 1b <u>3 weeks</u>		c. CITY OR TOWN <u>Jefferson City</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>St. Mary's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1002 West Main Street</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH ALBERT DAVIS</u>				4. DATE OF DEATH Month Day Year <u>September 10, 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>3-19-1903</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mo. State Highway Department</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Galveston, Texas</u>		11. BIRTHPLACE (City and state or country) <u>Galveston, Texas</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>George G. Davis</u>			13b. MOTHER'S MAIDEN NAME <u>Nelle E. O'Dwier</u>		14. NAME OF HUSBAND OR WIFE <u>Anne Comiskey Davis</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>486-18-5373</u>	17. INFORMANT Address <u>Mrs. Anne Davis 1002 W. Main J.C., 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>Acute Monocytic Leukemia (MONOCYTIC)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</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)					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 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>Aug. 10 / 59</u> to <u>Sept 6 / 59</u> and last saw him alive on <u>9-10-59</u> Death occurred at <u>9:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Dean A. Daylor M.D.</u>			22b. ADDRESS <u>Jefferson City Mo</u>			22c. DATE SIGNED <u>9-11-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 12, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson City, Mo.</u>				
24. FUNERAL DIRECTOR <u>Victor Buesch J.C.M.D.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11 September 1959</u>	26. REGISTRAR'S SIGNATURE <u>R.O. Norris, Md. - M. Richter Dep.</u>			

DOCUMENT

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

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 Victor Buescher

Licensed Embalmer No. 370

P. O. Address Jem

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.