

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035811

FILED VS. NOV 16 1959 28

Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 1208

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in lb <b>41 Years</b>		c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Ruffin Rest Home</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Flossie</b> Middle <b>Davis</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/11/89</b>	9. AGE (last birthday) <b>69 Yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Lawrence Co., Mo.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Coats</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Elmer Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Clovis Martin 1041 S. Main</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Bronchial</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
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 checked="" 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 <b>11,6,59</b> to <b>11,8,59</b> and last saw her/him alive on <b>11,8,59</b> Death occurred at <b>Burge Hospital 6:55 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
21a. SIGNATURE (Type or title) <b>J.D. Musick M. D.</b>			21b. ADDRESS <b>Springfield, Missouri</b>			21c. DATE SIGNED <b>11/9/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/10/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cemetery</b>		23d. LOCATION (City, town, or county) <b>Aurora, Missouri</b>				(State)	
24. FUNERAL DIRECTOR <b>Ayre-Goodwin</b>			ADDRESS <b>Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-9-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>		

DOCUMENT

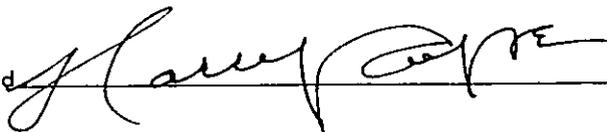
MEDICAL CERTIFICATION

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

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

Signed 

Licensed Embalmer No. 4594

P. O. Address Springfield, M

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.