

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036801

FILED VS NOV 10 1959

STATE FILE NUMBER

Registration District No. 181 Primary Registration District No. 4293 Registrar's No. 39

ENDED

1. PLACE OF DEATH a. COUNTY <u>LINCOLN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELSBERRY</u>	Length of stay in 1b	c. CITY OR TOWN <u>O'FALLON</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LaDelle Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. F. D. # 1</u>

3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>DAVIS</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>27</u> Year <u>1959</u>	
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5. SEX <u>Female</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>6/5/89</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>	11. BIRTHPLACE (City and state or country) <u>NEOSHO, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>WILLIE BURKHART</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN H. DAVIS</u>
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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>UNKNOWN</u>	17. INFORMANT Address <u>CECIL PRICE - 3050 SMILEY RD. - Bridgeton Mo</u>
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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>Carcinoma of the breast</u>		INTERVAL BETWEEN ONSET AND DEATH
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
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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.)
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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
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21. I attended the deceased from <u>Oct 23, 1959</u> to <u>Oct 27 1959</u> and last saw her alive on <u>Oct 26, 1959</u> Death occurred at <u>6:15</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>R. M. Hull Sr.</u> (Degree or title)	22b. ADDRESS <u>Clatsop Mo</u>	22c. DATE SIGNED <u>Oct 28, 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10/28/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FRIEDENS CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, Mo</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc - ST. LOUIS, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10/28/1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clarence Kientzy</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS NOV 10 1960

VS FEB 4 - 1960

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 *Robert East*

Licensed Embalmer No. 4017

P. O. Address Essex, _____

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.