

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 19 1959

59-041733

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **210134**

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 1 day		c. CITY OR TOWN Bismarck		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHALEY Middle GROVER Last DAVIS			4. DATE OF DEATH Month NOVEMBER Day 2 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6/19/1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Novelty Store		11. BIRTHPLACE (City and state or country) Bismarck, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Jerry Judson Davis			13b. MOTHER'S MAIDEN NAME Sarah Belle Shields		14. NAME OF HUSBAND OR WIFE Bertha Oehler Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Bertha Davis, Bismarck, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX WITH WIDESPREAD METASTASES						INTERVAL BETWEEN ONSET AND DEATH 3 YEARS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						161+		
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 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 MARCH 23, 1959 to NOV. 2, 1959 and last saw ^{her} him alive on NOV. 2, 1959 Death occurred at 6:05 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>R. V. Bradley</i> M. D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 11/3/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-5-59	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City, town, or county) Bismarck, Mo.				
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. NOV 4 1959		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> M. J. B.			

(Licensed Embalmer's Statement on Reverse Side)

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 Harvey Lake

Licensed Embalmer No. 4596

P. O. Address St Louis

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.