

MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026244

FILED VS. JUL 28 1960

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 116

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| 1. PLACE OF DEATH a. COUNTY Clay | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Missouri Lafayette | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Smithville | Length of stay in 1b 1 Week | c. CITY OR TOWN Lexington (rural) | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Smithville Community Hospital | | d. STREET ADDRESS (If outside, give location) 1 Mi. East | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First THOMAS Middle STEVEN Last DAVIDSON | 4. DATE OF DEATH Month July Day 16 Year 1960 |
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| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH May 4 1878 | 9. AGE (last birthday) 82 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner & Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Agri. | 11. BIRTHPLACE (City and state or country) Mayview, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S. |
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| 13a. FATHER'S NAME Thomas Davidson | 13b. MOTHER'S MAIDEN NAME Jane Ashford | 14. NAME OF HUSBAND OR WIFE |
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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) No. | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Mrs. Leone Moyer Lexington, Mo |
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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) Cerebral Vascular Accident | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Generalized Arteriosclerosis | 2 yrs. |
| | DUE TO (c) | |

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| 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 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.) |
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| 20c. TIME OF INJURY Hour 10:12 a.m. Month, Day, Year April 1959 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION 7/16/60 | COUNTY | STATE |
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| 21. I attended the deceased from April 1959 to 7/16/60 and last saw him alive on 7-16-60 Death occurred at 10:12 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE David R. Chiles M.D. (Deputy or title) | 22b. ADDRESS Smithville, Mo | 22c. DATE SIGNED 7-18-60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7/18/60 | 23c. NAME OF CEMETERY OR CREMATORY Lexington Memory Gardens | 23d. LOCATION (City, town, or county) Lexington, Mo. (State) |
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| 24. FUNERAL DIRECTOR Harold L. Walker Lexington, Mo. ADDRESS | 25. DATE RECD. BY LOCAL REG. 7-18-60 | 26. REGISTRAR'S SIGNATURE Marquette Hudgens |
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington

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.