

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1960

318

Primary Registration District No. 1003

Registrar's No.

7276

60-028238
STATE FILE NUMBER

INDEXED

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Calloway | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 9 Days | | c. CITY OR TOWN Fulton | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospital, Inc. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 704 Hickman Ave., | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Harry Middle Leland Last Davis | | | | 4. DATE OF DEATH Month July Day 20 Year 1960 | | | |
| 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 June 14, 1898 | 9. AGE (last birthday) 62 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (City and state or country) Calloway County Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Weldon L. Davis | | | 13b. MOTHER'S MAIDEN NAME Julia Threldeld | | 14. NAME OF HUSBAND OR WIFE Helen | | |
| 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. 500-09-9150 | | 17. INFORMANT Address Fulton Mrs. Harry L. Davis 704 Hickman 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) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CHRONIC NEPHRITIS DUE TO (c) HYPERTENSIVE VASCULAR DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 HRS 2 YRS. 5 YRS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592X | | | | | 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 checked="" 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 July 11, 1960 to July 20, 1960 and last saw him alive on July 20, 1960 Death occurred at 11:20 A.M. , 11:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Johna Carter, M.D. (Degree or title) | | | 22b. ADDRESS 1755 S. Grand Blvd. | | | 22c. DATE SIGNED 9-20-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE July 21, 60 | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem. | | 23d. LOCATION (City, town, or county) Fulton, Missouri | | | |
| 24. FUNERAL DIRECTOR ADDRESS Wallace Funeral Home-Fulton. Mo. | | | 25. DATE RECD. BY LOCAL REG. JUL 21 1960 | | 26. REGISTRAR'S SIGNATURE Neal Smith, M.D. m 8.13 | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 4 - 1960

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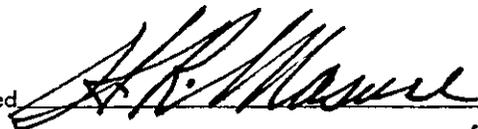
MAR 8 1961

VS AUG 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 _____ or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4996

P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.