

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033484
STATE FILE NUMBER

FILED VS SEP 1 1960

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 206

NDED

1. PLACE OF DEATH a. COUNTY <u>Scott</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u> c. CITY OR TOWN <u>Sikeston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>410 West North</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PAT</u> Middle <u>CLAYBOURN</u> Last <u>DAVIS</u>			4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</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>10/13/1887</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>5</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life event if retired) <u>Retired Utilities Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Light Co.</u>		11. BIRTHPLACE (City and state or country) <u>Farmington, Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>John Davis</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Magness</u>		14. NAME OF HUSBAND OR WIFE <u>Euna Atherton</u>	
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>No</u>		17. INFORMANT <u>Euna Davis, Sikeston, Mo.</u> Address _____	
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>Cerebral vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Nutritional anemia</u> DUE TO (c) <u>Inadequate food intake</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> <u>6 wks</u> <u>Chronic</u>	
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 <u>Mid 1959</u> to <u>8-18-60</u> and last saw him alive on <u>8-18-60</u> Death occurred at <u>4:25 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John Sargent M.D.</u>			22b. ADDRESS <u>Sikeston, Mo.</u>		22c. DATE SIGNED <u>8-19-60</u>	
23a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>		23b. DATE <u>8/21/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetary</u>		23d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Albritton Funeral Home Sikeston,</u>			25. DATE RECD. BY LOCAL REG. <u>MO 8-23-60</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ella Hunter</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 2 1960

SEP 1 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 Raymond L. D.

Licensed Embalmer No. 4798

P. O. Address Bernie, Y.

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.