

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035677

FILED VS SEP 26 1960 274

Primary Registration District No. 3052 Registrar's No. 323

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <i>Pettis</i>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>Sadalia</i>		a. STATE <i>Mo</i>		b. COUNTY <i>Pettis</i>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Bothwell Hospital</i>		Length of stay in lb <i>3 mo.</i>		c. CITY OR TOWN <i>Sadalia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <i>Broadway Cross Apt.</i>		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 Middle Last <i>Mattie Lee DAVIS</i>				4. DATE OF DEATH Month Day Year <i>Sept. 16 1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>9-22-1878</i>	
9. AGE (last birthday) <i>81</i>		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) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>Monroe Co. Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13a. FATHER'S NAME <i>William C. Swartz</i>		13b. MOTHER'S MAIDEN NAME <i>Margaret Ann Goodnight</i>		14. NAME OF HUSBAND OR WIFE <i>Sanford W. Davis</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs Eugene Walker</i> Address <i>Sadalia</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i>		DUE TO (b)					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes mellitus; Hypertension</i>						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 <i>June 21, 1960</i> to <i>Sept 16, 1960</i> and last saw her <i>alive</i> on <i>Sept. 16, 1960</i> . Death occurred at <i>1:50 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Thomas J. Hystrom M.D.</i>				22b. ADDRESS <i>Sadalia Mo</i>		22c. DATE SIGNED <i>9/17/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>9-18-1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Madison Mo</i>	
24. FUNERAL DIRECTOR ADDRESS <i>McLaughlin Bros Sadalia</i>				25. DATE RECD. BY LOCAL REG. <i>Sept 16, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Betty Yeager Deputy</i>	

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

Student _____
Signature of Student Embalmer

Signed K.P.M. Csary

Licensed Embalmer No. 3158

P. O. Address Sedalia

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.