

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041789

FILED VS. NOV 21 1960/40

Registration District No. 3024 Primary Registration District No. 103 Registrar's No.

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Boone				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette		Length of stay in 1b 5 hrs		c. CITY OR TOWN Rocheport		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee 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 BETTY Middle LOUISE Last DAVIS				4. DATE OF DEATH Month Nov. Day 14, Year 1960				
5. SEX Female	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 9/30/20	9. AGE (last birthday) 40	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Scotland Co. Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME James Arthur Found			13b. MOTHER'S MAIDEN NAME Sallie Wilson			14. NAME OF HUSBAND OR WIFE Roland Roger 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. None		17. INFORMANT Address Roland Roger Davis Rocheport, 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) Surgical Shock Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Internal Hemorrhage (Ruptured Bladder) DUE TO (c) Multiple Compound Leg Fractures							INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
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 checked="" type="checkbox"/> N- <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Car wreck						
20c. TIME OF DEATH 5:00 PM	Hour a.m. p.m. Nov 14 1960	Month, Day, Year	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.) Highway 124	20f. CITY, TOWN, OR LOCATION Fayette	COUNTY Howard	STATE Mo	
21. I attended the deceased from 11-18-60 to 11-14-60 and last saw her/him alive on 11-14-60 Death occurred at 11:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE W. Bloom (Degree or title)				22b. ADDRESS Fayette Mo		22c. DATE SIGNED 11-15-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11/17/60	23c. NAME OF CEMETERY OR CREMATORY Hickory Grove Cemetery		23d. LOCATION (City, town, or county) (State) Arbela, Missouri			
24. FUNERAL DIRECTOR Ralph A. Carr ADDRESS Fayette, Mo			25. DATE RECD. BY LOCAL REG. 11-15-60		26. REGISTRAR'S SIGNATURE Katherine Welch			

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

 ~~only~~ , Student Embalmer No.

working under my personal supervision.

Student

Signature of Student Embalmer

Signed

Ralph A. Cass

Licensed Embalmer No. 334

P. O. Address Gayette,

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.

00-22-11