RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

S DEC 23 1960

-60-047406

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11788

IDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY MADISON

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS — Length of stay in 1b D.O.A.

c. CITY OR TOWN COLLINSVILLE — Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MISSOURI PACIFIC HOSPITAL — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 843 ST. LOUIS ROAD — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ALVIN Middle ELLIOTT Last DAVIS

4. DATE OF DEATH Month DEC. Day 6, Year 1960

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 8-1-1895

9. AGE (last birthday) 65 YRS — 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) PURCHASING AGENT

10b. KIND OF BUSINESS OR INDUSTRY RAILROAD

11. BIRTHPLACE (City and state or country) ARDMORE, MO.

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME DAVID E. DAVIS

13b. MOTHER'S MAIDEN NAME SARAH ELLIOTT

14. NAME OF HUSBAND OR WIFE LEITA GASKILL DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes) give war or dates of service) WORLD WAR I

16. SOCIAL SECURITY NO. 702-12-4008

17. INFORMANT MRS LEITA DAVIS — Address COLLINSVILLE ILL.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Myocarditis; Coronary Occlusion about 75% bilateral chronic interstitial nephritis.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 4201

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her/him alive on _____

Death occurred at 2:50 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Coron

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 12-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE DEC 9, 1960

23c. NAME OF CEMETERY OR CREMATORY ST JOHN CEMETERY

23d. LOCATION (City, town, or county) COLLINSVILLE, (State) ILLINOIS

24. FUNERAL DIRECTOR HERR FUNERAL — ADDRESS COLLINSVILLE, ILL

25. DATE RECD. BY LOCAL REG. DEC 8 1960

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 357

P. O. Address Collinsville

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