

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012659

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 438

FILED MAY 8 1961

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 3 weeks | c. CITY OR TOWN Bolckow |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wilson Nursing Home 611 North 11th St. | | 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"/> |

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|--|---------------------------|---|---|---|--------------------------------|--------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last ORIN WILLIS DAVIS | | | 4. DATE OF DEATH Month Day Year April 24, 1961 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-3-73 | 9. AGE (last birthday) 87 | 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) retired laborer | | 10b. KIND OF BUSINESS OR INDUSTRY general | | 11. BIRTHPLACE (City and state or country) Barnard, Missouri | | 12. CITIZEN OF WHAT COUNTRY U S A |
| 13a. FATHER'S NAME Charles Davis | | 13b. MOTHER'S MAIDEN NAME Milia Patton | | 14. NAME OF HUSBAND OR WIFE Arminpa Davis | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 17. INFORMANT Address Mrs. Lulu Ault, Bolckow, Mo. | | | |

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|---|---|--|--|
| 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 2 days |
| IMMEDIATE CAUSE (a) Congestive Heart Failure | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerotic Heart Disease | | |
| | DUE TO (c) | | |
| 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 |

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|--|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED? YES <input 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 4-4-61 to 4-24-61 and last saw her alive on 4-23-61
Death occurred at 5:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|----------------------|--|--|-----------------------------|
| 22a. SIGNATURE <i>Clayton Smith</i> | | 22b. ADDRESS Social Welfare Board St. Joseph, Missouri | | 22c. DATE SIGNED 4-25-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 4-24-61 | 23c. NAME OF CEMETERY OR CREMATORY Bolckow Cemetery | 23d. LOCATION (City, town, or county) (State) Bolckow, Missouri | |
| 24. FUNERAL DIRECTOR BREIT & HAWKINS SAVANNAH | | 25. DATE RECD. BY LOCAL REG. May 2, 1961 | 26. REGISTRAR'S SIGNATURE <i>Wm. Clark Hardell</i> | |

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
SHOULD READ
ITEM NO.

C. Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James P. Hawkins

Licensed Embalmer No. 4536

P. O. Address Severnash

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.