

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028636

STATE FILE NUMBER

Registration District No. 70 Primary Registration District No. \_\_\_\_\_ Registrar's No. 45

AMENDED

FILED SEP 12 1961

1. PLACE OF DEATH a. COUNTY <u>Clark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wayland</u>	Length of stay in 1b <u>3 mo.</u>	c. CITY OR TOWN <u>Wayland</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If Not in hospital, give location) HOSPITAL OR INSTITUTION <u>City limits</u>	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 <u>Robert David Davis</u>			4. DATE OF DEATH Month Day Year <u>Sept. 1 - 1961</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>10/26/1936</u>	9. AGE (last birthday) <u>24</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Labor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Swift &amp; Co.</u>	11. BIRTHPLACE (City and state or country) <u>Canton Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Mamie Hess</u>	14. NAME OF HUSBAND OR WIFE <u>Judy Kay Davis</u>
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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.	17. INFORMANT <u>Judy Kay Davis - Wayland Mo.</u>
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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
IMMEDIATE CAUSE (a) <u>Hemorrhage from lungs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Due to rupture of pulmonary artery</u>	
DUE TO (c) <u>Crushing Injury</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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>Jack under Automobile give a way dropping car</u>
20c. TIME OF INJURY Hour <u>5-10</u> Month, Day, Year <u>9-1-61</u>		

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.) <u>Residence</u>	20f. CITY, TOWN, OR LOCATION <u>Wayland</u>	COUNTY <u>Clark</u>	STATE <u>Missouri</u>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. Channing D. Parones</u>	22b. ADDRESS <u>Lakota Mo.</u>	22c. DATE SIGNED <u>9-8-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept. 4 - 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Frazee Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Clark Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Wm. D. Yetting - Lakota Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-8-61</u>	26. REGISTRAR'S SIGNATURE <u>J. W. Bridges</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION

SEP 18 1961

MAY 22 1962

**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 Chas L. Putney

Licensed Embalmer No. 2965

P. O. Address Terre Haute, Ind.

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.