

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED DEC 21 1961 318

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11682

-61-046209

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>10 Yrs</u>		c. CITY OR TOWN <u>St. Louis</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>Bethesda Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2133 Geyer Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>James</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1961</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Can.</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>3-24-1905</u>		9. AGE (last birthday) <u>56</u>		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) <u>Chairman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Worker</u>		11. BIRTHPLACE (City and state or country) <u>Cordon Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>John E. Davis</u>				13b. MOTHER'S MAIDEN NAME <u>Rebecca Dillard</u>				14. NAME OF HUSBAND OR WIFE <u>Nora Davis</u>					
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 Address <u>Nora Davis 2133 Geyer Ave.</u>							
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 <u>24 hrs</u>			
IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u>													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b) <u>Bronchial Asthma</u>													
DUE TO (c) <u>24ix</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary Heart Failure, Massive Gastrointestinal Hemorrhage</u>								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 <u>12/4/61</u> to <u>12/13/61</u> and last saw him alive on <u>12/13/61</u> Death occurred at <u>7:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Donald E. Beckman M.D.</u>						22b. ADDRESS <u>4505 Virginia</u>			22c. DATE SIGNED <u>12/14/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Salem, Missouri</u>						
24. FUNERAL DIRECTOR <u>McLaughlin</u>				ADDRESS <u>2301 Lafayette Ave</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 15 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>					

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

Student _____
Signature of Student Embalmer

Signed James R. Chapman

Licensed Embalmer No. 455

P. O. Address St. Louis

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.