

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022263  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 59 Primary Registration District No. \_\_\_\_\_ Registrar's No. 110

**FILED JUN 26 1962**

VS 300  
Rev. 4/59

10190  
20190

3  
4 0  
5 1  
6  
7 0  
8 2  
9 20.1  
10  
11  
12 91-0  
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>CASS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CASS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>GRANDRIKER TWP</b>		c. CITY OR TOWN <b>HARRISONVILLE</b>	
Length of stay in 1b <b>1 Hour</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STRIKES SW HARRISONVILLE</b>		d. STREET ADDRESS (If outside, give location) <b>RT 2</b>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILL DAVIS</b>			4. DATE OF DEATH Month Day Year <b>JUNE 22 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1893</b>
9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <b>HARRISONVILLE, MO.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Thomas Davis</b>	
13b. MOTHER'S MAIDEN NAME <b>LUCINDA O'CONNOR</b>		14. NAME OF HUSBAND OR WIFE <b>GENEVA BLANCHE DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>IRA DAVIS</b>		Address <b>HARRISONVILLE, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
DUE TO (b) <b>Coronary insufficiency</b>			
DUE TO (c) <b>Arteriosclerosis</b>			
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
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 _____ to _____ and last saw <sup>her</sup> him alive on _____ Death occurred at _____ <b>8 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Edward S Jones MD</b>		22b. ADDRESS <b>Harrisonville, MO</b>	22c. DATE SIGNED <b>6-22-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6/24/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Orient Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>HARRISONVILLE, MO</b>
24. FUNERAL DIRECTOR <b>ATKINSON-DICKOY</b>		ADDRESS <b>HARRISONVILLE, MO</b>	25. DATE RECD BY LOCAL REG. <b>June 23-1962</b>
		26. REGISTRAR'S SIGNATURE <b>Mrs Gray Debrae</b>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert W. Atkinson

Licensed Embalmer No. 4902

P. O. Address Harrisonville, Mo

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.