

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029849

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 371 Primary Registration District No. 6260 Registrar's No. 15 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 30 1962

VS 300
Rev. 4/59

1 1120

2 1120

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7 0

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12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>WEBSTER</u>		a. STATE <u>MO.</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EAST FALLS SEYMOUR ROUTE 3</u> Length of stay in lb		c. CITY OR TOWN <u>SEYMOUR</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>ROUTE 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
<u>CALVIN WINFIELD DAVIS</u>		<u>7-23-62</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>NOV. 1, 1985</u> 9. AGE (last birthday) <u>76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WEBSTER Co. MO.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>CALVIN DAVIS</u>		13b. MOTHER'S MAIDEN NAME <u>SARA BARNETT</u>	
14. NAME OF HUSBAND OR WIFE <u>EMMA JANE</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. <u>NONE</u>		17. INFORMANT <u>KENNETH DAVIS SEYMOUR, MO. RT 3</u> Address	
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>ARICULAR FIBRILLATION</u>			<u>MONTHS?</u>
DUE TO (b) <u>ARTERIOBLENKOTIC HEART DISSASE</u>			<u>YEARS</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ASTHMA</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>16 July 1962</u> to <u>21 July 1962</u> and last saw her/him alive on <u>21 July 62</u> Death occurred at <u>10:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert L. Sample M.D.</u>		22b. ADDRESS <u>Transfield, Mo.</u>	
22c. DATE SIGNED <u>24 July 62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-25-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GENTRY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co. MO.</u>
24. FUNERAL DIRECTOR <u>Robert Bergman</u>	ADDRESS <u>Seymour, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>July 27, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Opal M. Good</u>

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Manassas 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.