

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-033603

STATE FILE NUMBER

Registration District No. 11 Primary Registration District No. 4034 Registrar's No. 83

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 15 1962

VS 300
Rev. 4/59

1 0050

2 0600

3

4 0

5 1

6

7 0

8 2

9 9490XH

10

11

12 1-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BARRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY McDONALD	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CASSVILLE		c. CITY OR TOWN 1 day	
c. FULL NAME OF HOSPITAL OR INSTITUTION Cassville Community Hosp		d. STREET ADDRESS (If outside, give location) Rocky Comfort,	
3. NAME OF DECEASED (Type or print) CHESTER VERNON DAVIDSON			4. DATE OF DEATH Month SEPTEMBER Day 30 Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing & Heating Cont.		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Jane, Missouri
13a. FATHER'S NAME Clarence C. Davidson		13b. MOTHER'S MAIDEN NAME Sarepta Testerman	
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 Crystal Davidson Rocky Comfort, Mo	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobar Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Myeloma			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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Sept 29, 1962 to Sept 30, 1962 and last saw him alive on Sept 29, 1962 Death occurred at 6:06 A. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James E. Goodling, M.D.		22b. ADDRESS Cassville, Mo.	
22c. DATE SIGNED 10-1-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-2-62	23c. NAME OF CEMETERY OR CREMATORY Rocky Comfort Cem.	
24. FUNERAL DIRECTOR ADDRESS W. Morris Roge Wheaton		25. DATE RECD. BY LOCAL REG. Oct 1-1962	
		26. REGISTRAR'S SIGNATURE Grace Williams	

USE BLACK INK OR TYPEWRITER RIBBON

