

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045643

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 101

FILED NOV 26 1962

VS 300
Rev. 4/59

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28030

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

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 Taney		a. STATE Arkansas b. COUNTY Carroll	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 6 Mi. S. of Hollister		c. CITY OR TOWN Blue Eye	
Length of stay in 1b few days		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION above		d. STREET ADDRESS (If outside, give location) above	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED			4. DATE OF DEATH
First Middle Last METTIE EUGENE DAVIS			Month Day Year November 10, 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1878
9. AGE (last birthday) 84		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Bellefonte, Ark.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Marion Sheppard	
13b. MOTHER'S MAIDEN NAME Mary Thomason		14. NAME OF HUSBAND OR WIFE Louis Henry Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Mo. May McFarland-St. Rt., Hollister,		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
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 10-23-62 to 11-10-62 and last saw ^(her) him alive on 11-5-62 Death occurred at 11 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles Spear MD		22b. ADDRESS Branson Mo	
22c. DATE SIGNED 11-17-62		23. NAME OF CEMETERY OR CREMATORY Blue Eye Cemetery	
23d. LOCATION (City, town, or county) Blue Eye, Missouri		23e. DATE RECD. BY LOCAL REG. 11-24-62	
23f. REGISTRAR'S SIGNATURE Robert Campbell		24. FUNERAL DIRECTOR Nelson Funeral Home-Berryville, Ark.	
24. ADDRESS		26. REGISTRAR'S SIGNATURE	

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 *[Handwritten Signature]*

Licensed Embalmer No. *65107*

P. O. Address *[Handwritten Address]*

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.