

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005557

STATE FILE NUMBER

Registered Date: **FILED MAR 11 1963** Primary Registration District No. **4071** Registrar's No. **14**

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Camden</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Camden</b>		
b. CITY OR TOWN <b>Camdenton</b>		Length of stay in 1b <b>5 yrs</b>	c. CITY OR TOWN <b>Camdenton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>414 Cedar Street</b>	
3. NAME OF DECEASED (Type or print) First: <b>Rebecca</b> Middle: <b>Jane</b> Last: <b>Davis</b>			4. DATE OF DEATH Month: <b>March</b> Day: <b>2</b> Year: <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14-1872</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months: <b>9</b> Days: <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At-Home</b>	11. BIRTHPLACE (City and state or country) <b>Tuscumbia Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>W. J. Welshlous</b>		13b. MOTHER'S MAIDEN NAME <b>Snoderly</b>		14. NAME OF HUSBAND OR WIFE <b>Clarence Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address <b>Lester Davis Camdenton Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr Hypertensive Heart Disease with Congestive Type Cardiac Failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 years.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis generalized</b>					Not known
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Arteriosclerosis</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>May 1958</b> to <b>Mar 2 1963</b> and last saw her alive on <b>Feb 28 63</b> . Death occurred at <b>11 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Thos. A. Wayland M.D.</b>			22b. ADDRESS <b>Camdenton, Missouri</b>		22c. DATE SIGNED <b>Mar 4 63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 4-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hammer Cemetery</b>	23d. LOCATION (City, town, or county) <b>Camden County</b>	Mo	
24. FUNERAL DIRECTOR <b>Robert H. Reed</b>		ADDRESS <b>Camdenton Mo.</b>	25. DATE RECD BY LOCAL REG. <b>Mar. 4-1963</b>	26. REGISTRAR'S SIGNATURE <b>Zilpha J. Isaac</b>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS:300  
Rev. 4/59  
**b150**  
**20150**  
3  
4 **1**  
5 **2**  
6  
7 **0**  
8 **2**  
**9443X**  
10  
11  
12 **90-0**  
13 **2-0**

**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 H. Reed*

Licensed Embalmer No. 3745

P. O. Address Camdenton 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.