

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005811

STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 40

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 11 1963	
1. PLACE OF DEATH	
a. COUNTY <u>Cooper</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u> Length of stay in 1b <u>24 days</u>	
c. CITY OR TOWN <u>New Franklin,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>106 S. Howard</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Olive</u> Last <u>DAVIS</u>	
4. DATE OF DEATH Month <u>March</u> Day <u>2,</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1870</u>
9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HR. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>
11. BIRTHPLACE (City and state or country) <u>Howard County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Henry J. Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Frances Walden</u>
14. NAME OF HUSBAND OR WIFE <u>Allison Davis</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>Mrs. Edna Starkey New Franklin, Mo.</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Feb 4-63</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> <u>10 years</u>	
DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>chr Bronchitis</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.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	
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.) <u> </u>
20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>Feb 4-63</u> to <u>mar 2-63</u> and last saw her alive on <u>mar 2-63</u> Death occurred at <u>11:10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u> </u>	22b. ADDRESS <u>Boonville, Mo</u>
22c. DATE SIGNED <u>3-4-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 5, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Fayette City Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Fayette, Missouri</u>
24. FUNERAL DIRECTOR <u>Markland - Hall</u> ADDRESS <u>New Franklin, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3/5/63</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

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Rev. 4/59
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USE BLACK INK OR TYPEWRITER RIBBON

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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 Tom D. Markland

Licensed Embalmer No. 4592

P. O. Address New Franklin 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.