

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-018798

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 37

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Taney		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Branson		Length of stay in 1b unknown	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION home Highway 165		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2404 BRENTWOOD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) SAM E. DAVIS			4. DATE OF DEATH Month APRIL Day 27 Year 1963
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 1/4/01
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME FOSTER DAVIS		11b. MOTHER'S MAIDEN NAME SUSAN JOHNSON	11. BIRTHPLACE (City and state or country) SEYMOUR, MO.
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO		12b. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. NAME OF HUSBAND OR WIFE PATRICIA DAVIS		14. NAME OF HUSBAND OR WIFE PATRICIA DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO			17. INFORMANT Address PATRICIA DAVIS, SPRINGFIELD, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Unknown DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH unknown
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 DOA to _____ and last saw her him alive on _____ Death occurred at 5 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Walter Cole Coronan Taney Co</i> (Degree or title)		22b. ADDRESS Branson, Missouri	22c. DATE SIGNED 4/30/63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/30/63	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
24. FUNERAL DIRECTOR H.H. LOHMEYER FUNERAL HOME ADDRESS SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 5-1-63	26. REGISTRAR'S SIGNATURE <i>Helen Campbell</i>

USE BLACK INK OR TYPEWRITER RIBBON

MAV 7-1963

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH

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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 Walter Cobb

Licensed Embalmer No. 4731

P. O. Address Blairwood, Ala

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.

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