

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 137

137

Primary Registration District No. 3523

Registrar's No. 20031168

STATE FILE NUMBER

VS 300
Rev. 4/59

1 0425

2 0425

3 2

4 0

5 1

6 1

7 1

8 2

9 131x

10 1-0

11 1-0

12 1-0

13 1-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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1. PLACE OF DEATH a. COUNTY <u>Henry</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> c. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give location) <u>Clinton General</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> c. CITY OR TOWN <u>Clinton</u> d. STREET ADDRESS (If outside, give location) <u>812 N 2nd St</u>	
3. NAME OF DECEASED (Type or print) First <u>Ullmon</u> Middle <u>L</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1964</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 13 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Rural Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Elizabeth Ark</u>
13a. FATHER'S NAME <u>Murphy T Davis</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Sanders</u>	14. NAME OF HUSBAND OR WIFE <u>Mabel</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>494-18-9747</u>	17. INFORMANT Address <u>Mrs Mabel Davis Clinton Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>asthma</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.)	
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 <u>8-13-64</u> to <u>8-15-64</u> and last saw her alive on <u>8-15-64</u> Death occurred at <u>6:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hugh B. Walker, M.D.</u>		22b. ADDRESS <u>Clinton, Mo</u>	22c. DATE SIGNED <u>8-17-64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-18-1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lowry City Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Lowry City Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Sickman-Dunning FH Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug. 18, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AUG 27 1964

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 P. L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton 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.