

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1932 OCT 26

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

29163
File No. _____
Registered No. 296
St. _____ Ward _____

1. PLACE OF DEATH
 County Jackson Registration District No. 398
 Township Blue Primary Registration District No. 3019
 City Independence (No. Independence Sanitarium)
 2. FULL NAME Mr. S. Kate Sheridan Davison
 (a) Residence, No. 1200 W. Walnut St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 5 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Holmes J. Davison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-27-1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>76</u>	<u>1</u>	<u>2</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. NONE

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Lockhartville (STATE OR COUNTRY) Nova Scotia

13. NAME Thomas Sheridan

14. BIRTHPLACE (CITY OR TOWN) Nova Scotia (STATE OR COUNTRY)

15. MAIDEN NAME Lois Claire

16. BIRTHPLACE (CITY OR TOWN) Nova Scotia (STATE OR COUNTRY)

17. INFORMANT Miss Nine L. Davison (ADDRESS) 1200 W. Walnut St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mound Grove DATE Oct. 1, 1932, 19____

19. UNDERTAKER Stahl's Funeral Home (ADDRESS) 815 W. Maple Ave.

20. FILED Sept 30, 1932 FK Cook Registrar.

2) MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 29, 1932, 19____

22. I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1932, to Sept. 1932, 19____
 I last saw him alive on _____, 19____ Death is said to have occurred on the date stated above, at 6:00A m.
 The principal cause of death and related causes of importance were as follows:
Arteriosclerosis
Cerebral Hemorrhage
 Date of onset _____

Other contributory causes of importance:
Cerebral Hemorrhage

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) Chas. Brooke, M. D.
 (Address) Independence Mo

