

REC'D MAR 16 1939

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

Duplicate of 12705-39

8147
Do not use this space.

1. PLACE OF DEATH

(a) County Wayne Registration District No. 990
(b) Township St. Francis Primary Registration District No. 6188 Registered No. _____
(c) City _____ (d) Street No. Kime No. St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Emma Wagner Davidson

(a) Residence, No. Kime, Missouri. St. D
(Usual place of abode, if no street address, write county or city) (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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. R. Davidson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 10, 1884

7. AGE YEARS 54 MONTHS 11 DAYS 16 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

FATHER 13. NAME Charles Wagner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Johanah Mollering
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

17. INFORMANT (ADDRESS) Wm. R. Davidson Kime, Missouri.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE March 1, 1939.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. F. Paschedag 2825 N. Grand Blvd.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 26, 1939 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1934, 1934 to Feb 23rd, 1939
last saw him alive on Sept, 1938. Death is said to have occurred on the date stated above, at 4:30A.M.
The principal cause of death and related causes of importance were as follows:

1934 Cancer of Maxilla
Hayden Lung and Me-
phritis
1939

Other contributory causes of importance: None
I attended Mrs. Davidson from 1934 constantly until 1938 when she was sent to a health resort and I was constantly on call.
Name of operation: Radical removal of maxilla
What test confirmed diagnosis? Surgical Was there an autopsy? No

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? No
If so, specify _____
(Signed) W. H. Wilson, M. D.
(Address) 4342 Warne Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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

Registered Apprentice No. _____, working under my personal supervision.

Signed *J. Sullivan*

Licensed Embalmer No. *1122*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

8147
Do not use this space.

1. PLACE OF DEATH

(a) County Wayne Registration District No. 890
(b) Township St Francois Primary Registration District No. 6188 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Emma Magnet Davidson
(a) Residence, No. Home Mo St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 26 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm R. Davidson

22. I HEREBY CERTIFY, That I attended deceased from 1 - 1934 to 2 - 23 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3 - 10 - 1884

I last saw h. _____ alive _____, 19____. Death is said to have occurred on the date stated above, at 4:30 p. m.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
34 11 16

Causes of meningitis, brain tumor and metastasis
Date of onset _____

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house
9. Industry or business in which work was done, as saw mill, bank, etc. war
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis not in Missouri

Other contributory causes of importance:
I attended Mrs Davidson from 1934 constantly until 1938 then she was sent to a health resort and resided there

13. NAME Charlie Magnet

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Johanna Mollinger

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

17. INFORMANT (ADDRESS) Wm R. Davidson
Home Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park 2-1 1937

19. FUNERAL DIRECTOR (ADDRESS) Wm F Paschedag
2825 - 71 Grand Blvd

20. FILED _____, 19____ Local Registrar.

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

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) G. H. Nelson, M. D.
(Address) 4362 Home Ave

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

EMERGENCY

