

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

14588  
Do not use this space.

LEAD MAY 18 1939

**1. PLACE OF DEATH**

(a) County Clark Registration District No. 191  
 (b) Township Leway Primary Registration District No. 2114  
 (c) City Leway (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME**

Sarah Jane Davidson  
 (a) Residence, No. \_\_\_\_\_ 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**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas H. Davidson  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 17-1858  
 7. AGE YEARS 80 MONTHS 7 DAYS 27 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Homemaker  
 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) Missouri

FATHER 13. NAME Cornelius Davidson

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

MOTHER 15. MAIDEN NAME Sarah Howell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Glenn Davidson Leway, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashton DATE Feb 11 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Keith Backus Myaconda, Mo

20. FILED May 2 1939 Attn: L. Sutterling Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 9 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 1938 to March 9 1939

I last saw her alive on March 9 1939. Death is said to have occurred on the date stated above, at 11 P.M.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset \_\_\_\_\_

Other contributory causes of importance: 93C

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_

If no, specify \_\_\_\_\_ (Signed) Lawrence E. Louis Do

(Address) Leway, Mo.

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.

RECEIVED

District Health Officer No. 10

District File Number 10-59-803

Date Filed MAY 10 1939

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

Fredrick Gerth, Jr.

, Registered Apprentice No. 168

working under my personal supervision.

Signed

Geo V. Baskett

Licensed Embalmer No. 1817

P. O. Address Wysconda N.Y.

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