

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

Dr. Upshaw

36102

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316

(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 795

(c) City SPRINGFIELD (d) Street No. St. Johns Hospital 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 Nell Davidson

(a) Residence, No. 2113 S. National 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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. E. Davidson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 22, 1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
1	64	5	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc. at Home

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) Curwensville Penn

FATHER

13. NAME J. L. Stifford

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Skowhegan Maine

MOTHER

15. MAIDEN NAME Ester Emery

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

17. INFORMANT (ADDRESS) J. E. Davidson 2113 S. National City

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE Nov. 1, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Schreyer Springfield, Mo.

20. FILED Oct 30, 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-1-39, 1939, to 10-30-39, 1939.
I last saw him alive on 10-30-1939. Death is said to have occurred on the date stated above, at 1:08 p.m.

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

Date of onset _____

Other contributory causes of importance:
In Diabetes Coma six days after a major operation

Name of operation Vaginal Hysterectomy Date of 10-24-39
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? No.
If so, specify _____
(Signed) Paul O. Upshaw, M.D. M. D.
1939 (Address) Springfield, Missouri

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.

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med. arts

STATEMENT BY LICENSED EMBALMER

X

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 2001 Registered No. 795
(c) City Springfield (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

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 5 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct 30, 1939 Chas. A. George, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__

I last saw h_____ alive _____, 19__ Death is said to have occurred on the date stated above, at _____ m.

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

Date of onset

Other contributory causes of importance:

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) Paul J. Shaw, M. D.

(Address) Springfield Mo

SUPPLEMENTARY

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

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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 2001
(c) City Springfield (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 Nell 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 <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>64</u>	MONTHS <u>5</u>	DAYS <u>8</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	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)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19__				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED _____ 19__				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 30 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19__ to _____ 19__

I last saw h_____ alive on _____ 19__ Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Diabetes mellitus
Date of onset _____

Other contributory causes of importance:
By diabetic Coma six days after a major operation for complete Prostatectomy
Name of operation Vaginal Prostatectomy Date of 10. 24-39
What test confirmed diagnosis? Udd. hdp. 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 so, specify _____
(Signed) Paul C. Zupshaw, M. D.
(Address) Springfield Mo

SUPPLEMENTARY

Local Registrar.

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