

Registration District No. 318Primary Registration District No. 2001

Registrar's No.

8639

1. PLACE OF DEATH: 2

(a) County Greene

(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 609 S Grant  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

In this community \_\_\_\_\_  
years, months or days)

8. (a) PRINT FULL NAME Erskin C. Davis 150

3. (b) If veteran, name war NO

3. (c) Social Security No. ✓

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Sarah Anne

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 14 1887  
(Month) (Day) (Year)

8. AGE: Years 52 Months 8 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman

11. Industry or business Day Watchman

12. Name Wm B Davis

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Martha J Hale

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sarah Anne Davis

(b) Address 609 S Grant

17. (a) Burial (b) Date thereof Nov 28 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director J. H. Klingner & Co

(b) Address Springfield Missouri

19. (a) 11-28-39 (b) Charles George M B  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 609 S Grant  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26  
year 1939 hour 3 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him dead live on Nov 26, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Bullet wound through head  
Duration \_\_\_\_\_

Due to Suicide

Due to Manic - Depressive Insanity

Other conditions 167  
(Include pregnancy within 3 months of death)

Major findings: 167  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence 11/26/39

(c) Where did injury occur? Springfield Greene Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home

While at work? no (Specify type of place) \_\_\_\_\_  
(2) Means of injury 45 caliber

23. Signature R. H. White (M. D. or other) MD

Address Cassius Greene County Date signed 11/28/39

**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.....

*Ogle Stone Jr.*  
.....  
working under my personal supervision.

Registered Apprentice No. *232*

Signed *Warren D. Noble*  
.....

Licensed Embalmer No. *4005*

P. O. Address *Springfield M*  
.....

**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.**

X