

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42587

Registration District No. 4

Primary Registration District No. 3001

Registrar's No. 303

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Traskville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Green-Smith Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
(Specify whether years, months or days) 9 days  
In this community 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan  
(c) City or town Green Castle  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Richard Nile Davidson  
8. (b) If veteran, name war 0 8. (c) Social Security No. 0

20. DATE OF DEATH: Month December day 22  
year 1939 hour 3 PM minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race 0 6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife 0 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 18 1939  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-13-39  
\_\_\_\_\_, 19\_\_\_\_, to 12-22, 1939  
that I last saw him alive on 12-22, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Malnutrition - dehydration  
Septicemia - peritonitis - lung abscess 2 weeks  
Due to Acute bacillary dysentery

Duration

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 136  
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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (Country) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature J. P. King M.D. (M. D. or other) !  
Address Traskville, Mo. Date signed \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Claude R. Davidson  
13. Birthplace Clark Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Wola Dale  
15. Birthplace Elmer Mo  
(City, town, or county) (State or foreign country)  
16. (a) Informant's own signature Claude R. Davidson  
(b) Address Green Castle Mo. 1939  
17. (a) Burial (b) Date thereof Dec 24  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Green Castle Mo  
18. (a) Signature of funeral director Elmer E. Hunt  
(b) Address Green City Mo  
19. (a) 1-2-39 (b) Spencer L. Ince  
(Date received local registrar) (Registrar's signature)

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 1-40-91

Date Filed JAN 8 1940

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Green City 7

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.