

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.

Registration District No. 461

Primary Registration District No. 5623

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Spain (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Rural Route Number 1 Box 127 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 61-2-8 years, months or days)

3. (a) PRINT FULL NAME Mrs. Mary Viola Davis
3. (b) If veteran, _____ name war _____
3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive deceased years
7. Birth date of deceased November 4 1878 (Month) (Day) (Year)

8. AGE: Years 61 Months 2 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Maude Nash
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Sallie Nash
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Davis
(b) Address _____

17. (a) Lexington (b) Date thereof Jan 16/1940 (City, town, or county) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director Green and Sons
(b) Address 204 So. 24 St

19. (a) Jan 15/1940 (b) Delia Bates (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Rural Route 1 # (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 12 year 1940 hour 6 minute 05 P. M.
21. I hereby certify that I attended the deceased from June 15 1939, to Jan. 12 1940, that I last saw her alive on Jan 12 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Hepatic abscess
struck pt. & rupture
Due to Locura 5 days
Due to 12.5
Other conditions no (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: no autopsy
Of operations _____
Of autopsy _____
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) no
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work _____ (Specify type of place) Means of injury _____
23. Signature J. S. Nash, M.D. (M. D. or other)
Address Lexington, Mo Date signed 1/15/40

RECEIVED
District Health Officer No. 8,
Apprentice File Number
Date Filed 7/20/40

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.....

George Henry Green, Registered Apprentice No. 235
working under my personal supervision.

Signed William J. Hurley
Licensed Embalmer No. 31015
P. O. Address 204 So. 24th St

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.