

Registration District No. 533Primary Registration District No. 3027Registrar's No. 7

FILED MAR 9 - 1940

1. PLACE OF DEATH:

- (a) County Macon
- (b) City or town Macon
- (c) Name of hospital or institution: 2
(If outside city or town limits, write "RURAL" and name of township)
- (If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____ (Specify whether)
- In this community Lifetime. (Specify whether
years, months or days)

3. (a) PRINT FULL NAME David Baker Davis. 1203. (b) If veteran, name war None 3. (c) Social Security No. none4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid. war6. (b) Name of husband or wife Unknown. 6. (c) Age of husband or wife if alive Unknown years7. Birth date of deceased June 17, 1862
(Month) (Day) (Year)8. AGE: Years 77 Months 6 Days 29 If less than one day
hr. min.9. Birthplace Towa (City, town, or county) (State or foreign country)10. Usual occupation Farmer.

11. Industry or business _____

12. Name Melshck Davis.13. Birthplace Ohio. (City, town, or county) (State or foreign country)14. Maiden name UNKNOWN (City, town, or county) (State or foreign country)15. Birthplace Unknown. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Robert Jones.(b) Address Macon, Mo.17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/40. (Month) (Day) (Year)(c) Place: burial or cremation Woodlawn Cemetery.18. (a) Signature of funeral director Albert Skinner.(b) Address Macon, Mo.19. (a) 2/5/40 (Date received local registrar) (b) Debra Hewitt (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Macon
- (c) City or town Macon. (If outside city or town limits, write "RURAL")
- (d) Street No. 210 South Ruby. (If rural, give location)
- (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16
year 1940 hour 8:00 A. Minute _____ M.21. I hereby certify that I attended the deceased from Nov. 29, 1939 to Dec. 14, 1939
that I last saw him alive on Dec. 14, 1939
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral arterio-sclerosis
Due to Generalized arterio-sclerosis
Due to _____Other conditions Fractured hip 1939
(Include pregnancy within 3 months of death)Major findings: Of operations none
Of autopsy none22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Fractured hip
(b) Date of occurrence Nov. Dec. 1939
(c) Where did injury occur? at home, Macon, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at homeWhile at work? no (Specify type of place) (e) Means of injury Fall23. Signature J. J. Turner (M. D. or other)
Address Macon, Mo. Date signed 1-29-40

Duration

1929?

PHYSICIAN

Underline the cause to which death should be charged statistically

RECEIVED

District Health Officer No. 10

District File Number 3-40-555

Date Filed MAR 8 1940

Dr. Turner.

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 *Geo. White*

Licensed Embalmer No. 4066

P. O. Address *Macon, Ga*

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.