

FILED MAR 16 1940

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

8459
Do not use this space.

1. PLACE OF DEATH *Nevada*
(a) County *Nevada* Registration District No. *875*
(b) Township *Beaver* Primary Registration District No. *3039*
(c) City *Nevada* (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 *MILFORD TAYLOR INNIS*
(a) Residence, No. *4217 main* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lucinda G. Innis*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug. 3-1859*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
80 6 20

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

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

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 23, 1940*

22. I HEREBY CERTIFY, That I attended deceased from *2-11, 1940, to 2-23, 1940*
I last saw him alive on *2-23, 1940*. Death is said to have occurred on the date stated above, at *6:30 P.M.*
The principal cause of death and related causes of importance were as follows:

Uremia
Cerebral arteriosclerosis
Hypertension heart
Arteriosclerosis hypertensiva

Date of onset *2-17-40*

Other contributory causes of importance:
Sensibility

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Vincennes Indiana*

13. NAME *James A. Innis*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indianapolis Indiana*

15. MAIDEN NAME *Parah Kummer*

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

17. INFORMANT (ADDRESS) *W. J. Innis Nevada, Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Newton B. Pl. DATE Feb 25, 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Fern Funeral Home Nevada, Mo*

20. FILED *2-29, 1940 Allen Hays Local Registrar.*

Name of operation _____ Date of _____

What test confirmed diagnosis? *Clinical* 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) *E. Braxton Davis*, M. D.
(Address) *Rogers Bldg. Nevada, Mo.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

2. S. NO. 4
50M-9-19-38
I X16805

75.132

MS 0M 2
1-3-11-1
100X 1-2

RECEIVED
District Health Officer No. 7,
District File Number 3-40-377
Date Filed 3-4-40

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 Personally

....., Registered Apprentice No.....
working under my personal supervision.

Signed Lloyd R. Winscott
Licensed Embalmer No. 3857
P. O. Address Wavada, Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 845-9

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 822

Primary Registration District No. 3039

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vermon Nevada
(b) City or town Nevada
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Milford Taylor Davis

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>6</u>	<u>20</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month Feb day 23
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that I last saw h. _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

Immediate cause of death
uremia + Chorea + spastic cerebral arteriosclerosis + hypertensive heart disease + hypertension
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 1931

Major findings:
Of operations _____
Of autopsy _____

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) _____ (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) (e) Means of injury _____
23. Signature C. Prater Davis (Physician or other)
Address Nevada Date signed _____

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

