

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10587

State File No. _____
Registrar's No. 122

Registration District No. 152 Primary Registration District No. 5216

1. PLACE OF DEATH:
(a) County Cass
(b) City or town (Rural) Camp Branch
(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 2
(Specify whether
In this community 4 yr
years, months or days)

8. (a) PRINT FULL NAME Mary Frances Davis
3. (b) If veteran, name war ✓ 3. (c) Social Security No. 120

4. Sex Female 5. Color or race White 5. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Geo Washington Davis 5. (c) Age of husband or wife if alive 9 years 1858
7. Birth date of deceased Oct 9 1858

8. AGE: Years Months Days If less than one day
81 4 22 hs min.

9. Birthplace Casper Co Mo. O
(City, town, or county) (State or foreign country)

10. Usual occupation Home-maker

11. Industry or business
MOTHER FATHER { 12. Name James Garland Ross
18. Birthplace Ry. 1
14. Maiden name Joanna Louise
15. Birthplace Waggon
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs J. H. Kirk
(b) Address Harrisonville Mo.

17. (a) burial (b) Date thereof Mar 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sum City Center

18. (a) Signature of funeral director RUNNENBURGER'S 1457
(b) Address HARRISONVILLE, MO. 115

19. (a) 2-4-40 (b) Mr. E. L. Stone
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cass
(c) City or town Rural Camp Branch
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 2
year 1940 hour 7 minute :00A.M.

21. I hereby certify that I attended the deceased from Feb 26, 1940, to Mar 2, 1940, that I last saw her alive on Mar 2, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia with chronic myocarditis
Due to: _____
Due to: _____

Other conditions (Include pregnancy within 3 months of death)
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) (b) Means of injury _____
23. Signature J. M. Scott (M. D. or other) Ph
Address Harrisonville Mo Date signed Mar 4

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

1940

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

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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 Ernest Runnenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 71

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 10587

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 152

Primary Registration District No. 2216

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Camp Branch Sew
(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)

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.

3. (a) PR Mary Frances Davis
FULL NAME

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

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

8. AGE: Years 81 Months 4 Days 22
If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 7
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Pneumonia
Bronchial
with Chronic Myo Carditis Duration _____

Due to _____
Due to _____

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

Major findings: _____
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) (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 J. H. Deatt (M. D. or other) _____
Address Harrisonville _____

SUPPLEMENTAL

S-10587 1940