

FILED OCT 23 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33388**

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **2390**

1. PLACE OF DEATH:

(a) County Vernon  
 (b) City or town Washington Township  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
State Hospital No 3 Nevada, Mo  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 30 days  
(Specify whether)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian  
 (c) City or town Chester  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Not known  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 23rd  
 year 1940 hour 5 minute 08 A.M.  
 21. I hereby certify that I attended the deceased from Aug 24th  
1940 to Sept 23rd 1940  
 that I last saw him alive on Sept 22nd 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death:  
Cerebral Hemorrhage  
 Due to meningeal vascular lines  
 Due to \_\_\_\_\_  
 Other conditions Senility 34  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy no  
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?  
795  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature G.S. Waraich (M. D. or other) \_\_\_\_\_  
 Address State Hospital, Nevada, Mo Date signed 9/23/40

3. (a) PRINT FULL NAME EFTON DAVIS

8. (b) If veteran, name war Not known 8. (c) Social Security No. None

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 22nd 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 10 29 hr. \_\_\_\_\_ min.

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

10. Usual occupation Blacksmith

11. Industry or business \_\_\_\_\_

12. Name Blutan Edward Davis

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

14. Maiden name Jane Williams

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

16. (a) Informant State Hospital Records

(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Hill Cem

18. (a) Signature of funeral director J.W. Maple

(b) Address Clery Mo

19. (a) 9-23-40 (b) Allen V. Kays  
(Date received local registrar) (Registrar's signature)

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

**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 \_\_\_\_\_

*J. W. Maples*

Licensed Embalmer No. 2985

P. O. Address Clener m

**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.**