

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35277

Registration District No. 2

Primary Registration District No. 4181

Registrar's No.

1. PLACE OF DEATH:

(a) County. Gasconade
(b) City or town. Bland
(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. entire life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Matilda Evelyn Davis

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

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

6. (b) Name of husband or wife W.C. Davis 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased March 28 1862 (Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 20 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

12. Name John Perkins

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

14. Maiden name Sarah Phillips

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

16. (a) Informant Mr. Ben Hamlin (b) Address Bland Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery - Bland

18. (a) Signature of funeral director

(b) Address Bland - Missouri

19. (a) (Date received local registrar) (b) C.A. Bunge (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade
(c) City or town Bland (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18 year 1940 hour 1 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1 1938 to Oct 18 1940 that I last saw her alive on Oct 18 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis

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?

(Specify type of place) (e) Means of injury

23. Signature C.A. Bunge (M. D. or other)

Address Bland Mo. Date signed Oct 19 40

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

Chester Sessmann

, Registered Apprentice No. 216

working under my personal supervision.

Signed

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address Owensville, 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. **35277**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **302**

Primary Registration District No. **4181**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County **Bay County**
(b) City or town **Blair**
(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

Matilda Evelyn Dair

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 **m**

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 **78** Months **6** Days **20** If less than one day _____ 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)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) **Oct 18-48** (b) **E. H. Bunge** (c) _____ (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.

20. DATE OF DEATH

- Month **Oct** day **18** year **1948** 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 _____

- 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) (e) Means of injury _____

23. Signature **E. H. Bunge** (M. D. or other) _____

- Address **Blair** Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

2011/02/20