

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. White
42532
State File No.
Registrar's No. 1006

Registration District No. 318

Primary Registration District No. 8001

1. PLACE OF DEATH
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
714 S. Fort
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 day years, months or days) _____

3. (a) PRINT FULL NAME Charles Gilbert Davis
(b) If veteran, name war no
(c) Social Security No. no

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased December 15 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 0 1 hr. min.

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

10. Usual occupation Inf.

11. Industry or business _____

MOTHER FATHER { 12. Name William Lewis Davis
13. Birthplace Hardin County Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Verna Woodruff
15. Birthplace Unknown Nebraska
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Lewis Davis
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Dec. 17 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 12-17-40 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 714 S. Fort
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16
year 1940 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from Dec 15, 1940, to Dec 16 1940; that I last saw him alive on Dec 16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Neural Hemorrhage Duration 24 hrs

Due to (Normal delivery)

Due to _____

Other conditions Prematurity 8 1/4 months
(Include pregnancy within 3 months of death)

Major findings: Of operations 160 P
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 _____

Signature R. H. White (M. D. certifier)
Address Springfield Date signed 12-16-40

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

19
3
6

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.....

Handwritten signature

....., Registered Apprentice No.

working under my personal supervision.

Signed

Handwritten signature

Licensed Embalmer No. *2033*

P. O. Address

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, fact should be so stated above.

X