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9  
X2315

MAR 14 1941

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 407 N 8th St  
(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 Mo (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 407 N 8th St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 22<sup>nd</sup>  
year 1941 hour 2:25 minute A. M.

21. I hereby certify that I attended the deceased from Feb 21  
1941, to Feb 22, 1941

that I last saw him alive on Feb 21, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Paralytic

Paralysis observed on her brain

Due to arteriosclerosis

Due to arteriosclerosis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy none

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? no

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature H. G. Bradford (M. D. or other) D

Address Columbia Mo Date signed 2/24/41

3. (a) PRINT FULL NAME George Thomas Davis

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

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

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

7. Birth date of deceased December 2 1887  
(Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FARMER

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

12. Name Thomas F Davis

13. Birthplace Callaway Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name EMMA GILLASPIE

15. Birthplace Boone Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Maudie Davis

(b) Address 407 N 8th St

17. (a) Burial (b) Date thereof Feb 23-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Millersburg

18. (e) Signature of funeral director R. O. Wier

(b) Address Columbia Mo

19. (a) 2/24/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

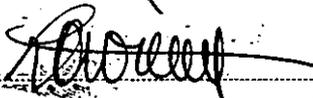
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

82A

**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:  \_\_\_\_\_  
Licensed Embalmer No. 3183  
P. O. Address Columbia, 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, fact should be so stated above.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

6243  
Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 73  
 (b) Township ..... Primary Registration District No. 3006 Registered No. ....  
 (c) City Columbia (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 Geo Thomas Davis

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
53 2 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22, 1941

22. I HEREBY CERTIFY, That I attended deceased from ..... to .....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Paralysis  
Formerly operated on for brain tumor

Date of onset

Other contributory causes of importance:

56 d

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....

If so, specify .....

(Signed) ....., M. D.

(Address) .....

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

a Bradford MD Columbia Mo

S-6243