

No. 1346
7-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11303**

Registration District No. **553**

Primary Registration District No. **3027**

Registrar's No. **28**

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town Macon
 (c) Name of hospital or institution 313 Ogden St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 (Specify whether
 In this community 1 years, months or days)

3. (a) PRINT FULL NAME Hellie Davis
 (b) If veteran, name war none
 (c) Social Security No. none

4. Sex Female 5. Color or race negro
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Clyde Davis
 6. (c) Age of husband or wife if alive years
 7. Birth date of deceased Dec 24 - 1892
 (Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 16 If less than one day
 hr. min.

9. Birthplace: College Mound Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation: house keeper

11. Industry or business:

MOTHER FATHER
 12. Name Gas Gorham
 13. Birthplace College Mound Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Ela Reynolds
 15. Birthplace Jacksonville Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ela Gorham
 (b) Address College Mound Mo

17. (a) Burial (b) Date thereof Mar 12 - 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Woodlawn Cem.

18. (a) Signature of funeral director Albert Skinner
 (b) Address Macon Mo

19. (a) 3/20/41 (b) Seata Newton
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Macon
 (c) City or town Macon Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 313 Ogden St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 6 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 10
 year 1941 hour 7:45 minute 2 M.
21. I hereby certify that I attended the deceased from Jan 10
1941, to Mar 10, 1941,
 that I last saw her alive on MAR 9
 and that death occurred on the date and hour stated above.

Immediate cause of death ACUTE CONGESTIVE HEART FAILURE
 Due to Lymphosarcoma
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy lymphosarcoma of spleen, lung, g. tract, uterus & ov.
 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?
476 (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature E. Horsinger (M. D. or other) DO
 Address 118 1/2 Vine St Macon Mo. Date signed Mar 19 1941

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

55

1941 NOV 19

RECEIVED

District Health-Officer No. 10

District File Number 4-41-724

Date Filed APR 10 1941

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 *George H. ...*

Licensed Embalmer No. 4064

P. O. Address Mason, Miss.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11303

Registration District No. 533

Primary Registration District No. 3027

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(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

3. (a) PRINT FULL NAME Nellie Davis
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race Negro
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 Months Days If less than one day
48 2 16 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 (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar day 10
year 1941 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 acute Congestive heart failure Duration _____
lympho sarcoma of spleen lung & tract uterus & ovaries

Due to lympho sarcoma of spleen lung & tract uterus & ovaries
Other conditions Primary seat of malignancy believed to be the retroperitoneal lymph glands.
(Include pregnancy within 3 months of death)

Major findings lymph glands PHYSICIAN
Of operations be the retroperitoneal lymph glands
Of autopsy H. H. H.
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 H. H. H. (M. D. or other) MD

Address Macon Mo. Date signed 9/15/41

SUPPLEMENTARY

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

MOTHER FATHER

1941

S-11303