

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MAY 1941
STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14621
Registrar's No. 316

Registration District No. 318
Primary Registration District No. 5440

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(c) Name of hospital or institution: County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Wks.
In this community About 15 Years
(Specify whether years, months or days)

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

4. Sex M. 5. Color or race W.
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased Sept. 6 1883
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 6
If less than one day hr. min.

9. Birthplace Unknown
(City, town, or county) (State or foreign country)
10. Usual occupation Unknown

11. Industry or business
12. Name Norman Davis
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Tadlock
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Mae Slavens
(b) Address Springfield, Mo.
17. (a) Burial (b) Date thereof 4/13/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood (Cem)
18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.

19. (a) 4-13-41 (b) W. E. Hardley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1607 W. Scott
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1941 hour 8 minute 40 A.M.
21. I hereby certify that I attended the deceased from 3-28-41
to 4-12-41, 19____, to 4-12-41, 19____;
that I last saw him alive on 4-12-41, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Aneurysm

Due to Syphilis
Due to _____
Other conditions (Include pregnancy within 3 months of death)

Major findings: no operation
Of operations _____
Of autopsy no autopsy

Duration
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 James R. Amos (M. D. or other) _____
Address Springfield Date signed 4-14-41

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

Floyd W. Gal

Licensed Embalmer No.

2910

P. O. Address

629 Walnut

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