DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32677

FILED OCT 14 1941

Registration District No. 7 Primary Registration District No. 6040 Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County: Saline

(b) City or town: Miami (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: no (Specify whether years, months or days)

In this community: 33 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Saline 57

(c) City or town: Miami (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Thomas David

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: December (Month) 28th (Day) 1867 (Year)

8. AGE: Years 73 Months 8 Days 29 If less than one day hr. min.

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

10. Usual occupation: farm

11. Industry or business:

FATHER 12. Name: Ferdinand David

FATHER 13. Birthplace: don't know (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Catherine Henderson

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

16. (a) Informant: Mrs. Thos. David.

(b) Address: Miami, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9-29-'41 (Month) (Day) (Year)

(c) Place: burial or cremation: Miami, Mo.

18. (a) Signature of funeral director: Hill Brothers

(b) Address: Slater, Mo.

19. (a) Sept 29 (Date received by local registrar) (b) Mrs Celina Hale (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th year 1941 hour minute D. M.

21. I hereby certify that I attended the deceased from Sept. 16 1941, to Sept. 27 1941, that I last saw him alive on Sept. 27 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Cancerous Myocarditis with Confusion due to about 8 days

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): 93d

Major findings: Of operations:

Of autopsy: None

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Frank Hullen (M. D. or other)

Address: Miami, Mo Date signed 9/28/41

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 8,

District File Number

Filed 10-8-41

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 Edgar Moore

Licensed Embalmer No. 4187

P. O. Address Slater 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.

No. 2B
-8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32677

Registration District No. 797 Primary Registration District No. 6040 Registrar's No.

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Marshall
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Thomas David
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Nancy
6. (c) Age of husband or wife if alive: 68 yrs years
7. Birth date of deceased: Dec 28 1867 (Month) (Day) (Year)
8. AGE: Years 73 Months 8 Days 28 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (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) 9-29-41 (Date received local registrar) (b) Mrs Arlin Hall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19..., to 19...; that I last saw h alive on 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY