

FILED AUG 24 1942

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U. S. No. 2
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 266 (434)Primary Registration District No. 266 5368Registrar's No. 11

1. PLACE OF DEATH:

(a) County Dent
 (b) City or town Sinkin rural
 (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 all her life (Specify whether)
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? X 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31
 year 1942 hour 2 minute 2 P M.

21. I hereby certify that I attended the deceased from
Mar. 7, 1934 to Jan. 31, 1942
 that I last saw her alive on Jan. 25, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial degeneration
 Duration _____

Due to _____
 Due to _____

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

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? _____

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

23. Signature L. L. Henson (M. D. or other)
 Address Salem, Mo. Date signed 2-2-42

8. (a) PRINT FULL NAME Mrs Delores Hazel Davis

8. (b) If veteran, name war X 8. (c) Social Security No. X

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Glen Davis 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Feb 7 1904
 (Month) (Day) (Year)

8. AGE: Years 37 Months 11 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business X

12. Name James Andrew Stagner

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

14. Maiden name Mary Katherine Shelton

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

16. (a) Informant Bernice Stagner
 (b) Address Salem Mo

17. (a) burial (b) Date thereof Feb 2/42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bay View

18. (a) Signature of funeral director Carl H. Spencer
 (b) Address Salem Mo

19. (a) 2-2-42 (b) J. D. Wood
 (Date received local registrar) (Registrar's signature)

1177 (Licensed Embalmer's Statement on Reverse Side)

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

3000

RECEIVED

District Health Officer No. 5,

District File Number 742614

Date Filed 7-18-42

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.....

[Handwritten Signature]
signed

Licensed Embalmer No.....

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, above space should be left blank.