

S. No. 2  
M-5-42  
5-17-38

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15116  
State File No. 15116  
Registrar's No. 225

Registration District No. 280

Primary-Registration District No. 5966

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

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Edgerton Rural No. 1  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution. None (Specify whether  
In this community 78 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte

(c) City or town Edgerton No. Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 4-ri S.W. Rural No. -1  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. 0

3. (a) PRINT FULL NAME Minor Davidson

3. (b) If veteran, name war None

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 18th.  
year 1943 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan. 15  
1943 to Apr. 18, 1943.

that I last saw ~~him~~ her alive on Apr. 14, 1943.  
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mollie Davidson

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Dec. 27th. 1864  
(Month) (Day) (Year)

Immediate cause of death Myocardial infarction  
Tenney, Chronic nephritis,  
Dropsy, Infirmitates of old  
Due to age.

Due to \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>3</u>	<u>12</u>	_____ hr. _____ min.

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.

9. Birthplace Carden Point Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Harring

11. Industry or business None

MOTHER FATHER {

12. Name Noah Davidson

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

14. Maiden name Lusinda Brown

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

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 John A. Robinson, M.D.  
Address Edgerton, MO Date signed 4-19-43

16. (a) Informant Lusinda Davidson

(b) Address Edgerton Missouri

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 4/20/1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Ridgley Cemetery

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address Dearborn Missouri

19. (a) 4/19/43 (Date received local registrar)

(b) Mrs. Clay Biffle (Registrar's signature)

1209 (Licensed Embalmer's Statement on Reverse Side)

**RECEIVED**

District Health Officer No. Platte

District File Number 5-43-44

Date Filed 5-3-43

**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 Lucian Davis

Licensed Embalmer No. 4160

P. O. Address Dearborn 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-116  
Registrar's No. 22

Registration District No. 280

Primary Registration District No. 5965

1. PLACE OF DEATH:

(a) County Platte  
(b) City or town 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 \_\_\_\_\_ years, months or days) 78 yrs

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 Minor Davidson

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 Mollie 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Dec 27 - 1864  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Regina Davis

(b) Address Harborn mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I have now \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-15116