

FILED JUN 12 1948

Registration District No. 134

Primary Registration District No. 4-1-9-8-4207

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Harrison

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 55 yrs (Specify whether years, months or days)

In this community: 55 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Harrison

(c) City or town: Blythe Dale
(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: Effie Davis

3. (b) If veteran, name war: No. 3. (c) Social Security No.: 76

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

6. (b) Name of husband or wife: John Davis, Dec. 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: 12 - 7 - 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>5</u>	<u>12</u>	_____ hr. _____ min.

9. Birthplace: Blythe Dale, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: _____

12. Name: James Martin Davis

13. Birthplace: Feb. 1
(City, town, or county) (State or foreign country)

14. Maiden name: Augusta Ann Hart
(City, town, or county) (State or foreign country)

15. Birthplace: Mercer County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Reddie Harris

(b) Address: Cedar Rapids, Ia.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-21-43
(Month) (Day) (Year)

(c) Place: burial or cremation: Blythe Dale

18. (a) Signature of funeral director: A. M. Haas

(b) Address: Bethany, Mo.

19. (a) 5-22-43 (Date received local registrar) (b) S. H. Shair (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 18 year: 1943 hour: 5-1 minute: 1 A. M.

21. I hereby certify that I attended the deceased from Jan 10, 1943 to May 18, 1943; that I last saw him alive on May 18, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic Pneumonia Duration: 1 week
Due to: Post Surgical Debility 6 weeks

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) (c) Means of injury: 2

23. Signature: James B. Ryan (M. D. or other) D.O.
Address: Blythe Dale, Mo. Date signed: 5/17/43

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.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. _____

Registration District No. 134

Primary Registration District No. 4207

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Blythe Dale
(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

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 Effie Davis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 55 Months 5 Days _____ (If less than one day _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Bronchial Pneumonia

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

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PHYSICIAN
Underline the cause to which death should be charged statistically.

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

S-17958