

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28117**
Registrar's No. **62**

Registration District No. **101**

Primary Registration District No. **5414**

1. PLACE OF DEATH:

(a) County **Douglas**
(b) City or town **Rolla Washington**
(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 _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Douglas**
(c) City or town **Ava**
(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 **Hellie Pearl Davis**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**

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

7. Birth date of deceased **August 1, 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 29 hr. min.

9. Birthplace **Vernon Co. near Nevada, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business _____

12. Name **Isaac Whitworth**

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

14. Maiden name **Anna Lee**

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

16. (a) Informant **Dr. J. J. Mayer**

(b) Address **Stuffed Kears**
17. (a) **Burial** (b) Date thereof **8-1-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Good Hope**

18. (a) Signature of funeral director **Clinkingbeard Funeral**
(b) Address **Ava, Missouri**

19. (a) **9-9-1-43** (b) **Thelma Waters**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30** year **1943** hour **4** minute **15** A.M.

21. I hereby certify that I attended the deceased from **near** **10:40** to **July 25**, 19**43**
that I last saw her alive on **July 25**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Vascular Heart disease**

Duration

Long study

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 **R. M. Norman** (M. D. or other) _____
Address **Ava Mo** Date signed **7/31/43**

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

MOTHER FATHER

1056

RECEIVED

District Health Officer No. 6,

District File Number 943-1016

Date Filed 9-9-43

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 W.B. Hutchison

Licensed Embalmer No. 3731

P. O. Address Ova Md

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.