

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 44070  
Registrar's No. 130

Registration District No. 360  
FILED JAN 6 1944

Primary Registration District No. 3076

1. PLACE OF DEATH:  
(a) County VERNON  
(b) City or town NEVADA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
CITY HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County BATES  
(c) City or town Rich Hill MO  
(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 IDA LOUIS DAVIS  
3. (b) If veteran, name war X 3. (c) Social Security No. X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month DEC day 24  
year 1943 hour 8 minute A-M

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife STERLING DAVIS 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased MAY 21 - 1872  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 9, 1943 to Dec 24, 1943  
that I last saw her alive on Dec 24, 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years 71 Months 7 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Massive Chyloperitonitis of the abdomen & pelvis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace BATES CO MO (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation HOUSEWIFE

Major findings: Of operations Consumed 2 yrs ago  
Of autopsy None

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name WM. H. CATTON  
13. Birthplace VA (City, town, or county) (State or foreign country)  
14. Maiden name AMANDA RATEKIN  
15. Birthplace MO (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 Wm. Hallen MD (Physician)  
Address Nevada MO Date signed 12/27/43

16. (a) Informant LOWELL DAVIS  
(b) Address RICH HILL MO  
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-26-43 (Month) (Day) (Year)  
(c) Place: burial or cremation GREENLAWN  
18. (a) Signature of funeral director Booths  
(b) Address Rich Hill Mo  
19. (a) 12-28-43 (Date received local registrar) (b) Agel B. Bewick (Registrar's signature)

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

Funeral Home Office No. 1.  
12-43-430  
1-5-44

**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 *John G. Glendon*  
Licensed Embalmer No. *3585*  
P. O. Address *Butler 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan.  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Nevada  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: City Hosp.  
(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)

3. (a) PRINT FULL NAME John L. Davis

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

4. Sex 7 5. Color or 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 \_\_\_\_\_ year

7. Birth date of deceased May 27  
(Month) (Day) (Year)

8. AGE: Years 71 Months \_\_\_\_\_ 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) \_\_\_\_\_ (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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 24  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death massive

Due to the abdomen of Pelvis ovarian carcinoma primary 49a

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Confirmed 5 yrs. ago  
Of operations at Surgery

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) (a) Means of injury \_\_\_\_\_

23. Signature Wm. Keller MD (M.D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

6 yrs

4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-44070