

FILED FEB 20 1944
Registration District No. 300

Primary Registration District No. 3076

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Nevada
(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 22 days
(Specify whether
In this community 55 years 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nevada
(c) City or town Nevada Mo 108
(If outside city or town limits, write "RURAL")
(d) Street No. 926 W. Aushire St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME JOE. ANV. DAVIS

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

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

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

7. Birth date of deceased Aug - 1873
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Not known
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

12. Name Herry Clay Davis

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Sam Niles

(b) Address Nevada Mo

17. (a) Removal (b) Date thereof Jan-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pacific Mo

18. (a) Signature of funeral director Ferry General Home

(b) Address Nevada Mo

19. (a) 1-10-44 (b) Bozel B. Beuch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7
year 1944 hour 4 minute PM M.

21. I hereby certify that I attended the deceased from Nov 15, 1943, to Jan 7, 1944
that I last saw him alive on Jan 7, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Block
Due to Poor circulation
Due to Arterio Sclerosis

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

Major findings: Of operations 95a

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? _____

(Specify type of place) While at work? _____ (e) Means of injury no

23. Signature J. M. Light (M. D. or other)

Address Nevada Date signed 1/9/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 7,
District File Number 1-44-34
Date Filed 2-4-44

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 W/S
....., Registered Apprentice No. 1432
working under my personal supervision.

Signed W. E. Ferry
Licensed Embalmer No. 1432
P. O. Address Neerda 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.