

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10691
Registrar's No. 28

FILED APR 12 1944

Primary Registration District No. 5285

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Rural Washington Twp
(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 Missouri (b) County Clark 23
(c) City or town Rural 0
(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 _____ 0

3. (a) PRINT FULL NAME Mary Jane Davis

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

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

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

7. Birth date of deceased May 6th 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 10 15 hr. min.

9. Birthplace Near Williamstown Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name Geo W. Adams

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

14. Maiden name Martha Oliver

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

16. (a) Informant _____

(b) Address _____

17. (a) Burial (b) Date thereof March 24
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deer Ridge Gemetry

18. (a) Signature of funeral director W. D. Baskett

(b) Address Wyandora, Mo.

19. (a) 3-31-44 (b) P. S. Boston
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 21 day
year 1944 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from June 17th, 1943, to Mar 21, 1944;
that I last saw her alive on Mar 21, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach 1 yr
H6P

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 Dr. C. E. Todd 2 M.D. or other _____

Address Williamstown Date signed 3/29/44

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

1275

RECEIVED

District Health Officer No. 10

District File Number 4-44-718

Date Filed APR 8 1944

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No.

P. O. Address.....

George V. Baskett
1817
Wpanda

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 70

Primary Registration District No. 5285

APR 14

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

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Central Washington Mo
(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

3. (a) PRINT FULL NAME Mary Jane Davis
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____ years

7. Birth date of deceased may 6
(Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days _____ (If less than one day, _____ min.)

9. Birthplace _____ (City, town, or county) (State or foreign country) mo.

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 William Davis

(b) Address Williamtown, mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Clark
(c) City or town Washington Imp (Rural)
(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 March year 1944 hour _____ minute _____ M.

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

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

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

10691