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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37286

FILED DEC 11 1944
Registration District No. 42

Primary Registration District No. 5135

State File No. _____
Registrar's No. 365

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Quincy "Rural"
(c) Name of hospital or institution: Home
(d) Length of stay: In hospital or institution 1
In this community 1 year, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Butler 12
(c) City or town Quincy "Rural"
(d) Street No. _____
(e) Citizen of foreign country? No

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 30
year 1944 hour 2 minute 30 A.M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Evelyn Davis
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased: Oct-30-1909

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: Bright's Disease Duration 2 yrs
rupture

8. AGE: Years 34 Months 11 Days 16
If less than one day _____ hr. _____ min.

Due to not known
Due to _____

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

10. Usual occupation Farming & Fish Market

MOTHER FATHER
11. Industry or business _____
12. Name Edward Davis
13. Birthplace Mo.
14. Maiden name Ellen Thompson
15. Birthplace Mo.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Ellen Merritt
(b) Address Campbell Mo.
17. (a) Burial (b) Date thereof Oct. 31-44
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(c) Place: burial or cremation Campbell Mo
18. (a) Signature of funeral director Pauline F. H.
(b) Address Campbell Mo.
19. (a) 11-14-44 (b) Belle Turner
(Date received local registrar) (Registrar's signature)

While at work? _____ (a) Means of injury _____
23. Signature W. E. ... (M. D. or other) _____
Address Salome Date signed 11/4/44

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

RECEIVED

District Health Office No. 2, r

District File Number 1244-1603

Date Filed 12-7-44

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 Kristina M. Lendesa

Licensed Embalmer No. 4-227

P. O. Address Campbell, 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. Dee

Registration District No. 43

Primary Registration District No. 5135

Registrar's No. 365

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Rural Ash Hill 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)

3. (a) PRINT FULL NAME Buell E. Davis

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

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

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

7. Birth date of deceased Oct 30 1900
(Month) (Day) (Year)

8. AGE: Years 34 Months 1 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 _____

(b) Address _____

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

(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 Oct Day 10 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 Bright's Disease

Due to not known Duration _____

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 _____

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

SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

37286