

Registration District No. 349

Primary Registration District No. 6186

Registrar's No.

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

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1. PLACE OF DEATH:

(a) County Stone

(b) City or town James P. Rural
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 60 yrs.
years, months or days

3. (a) PRINT FULL NAME JOHNATHAN H. DAVIS

3. (b) If veteran, name war No

3. (c) Social Security No. _____

4. Sex M. 5. Color or race W.

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Elizabeth Davis

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

7. Birth date of deceased SEPT 25 1849
(Month) (Day) (Year)

8. AGE: Years 95 Months _____ Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Ark. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name Thos. Davis

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Darrel

15. Birthplace mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edith Coy

(b) Address Reeds Spring Mo

17. (a) Reeds Cemetery (b) Date thereof Oct 21 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Frank Davis (acting)

(b) Address Reeds Spring Mo

19. (a) Oct 21-1944 (b) Charles D. Scott
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone 104

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 20 day 20th
year 1944 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Oct 20 to Oct 20, 1944.

that I last saw him alive on Oct 20, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 10 days

Due to _____

Due to 107

Other conditions (Include pregnancy within 3 months of death) 2. S. Shumate MD

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 0

23. Signature P. S. Shumate (M. D. or other)

Address Reeds Spring Mo Date signed 10/21/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

1195

RECEIVED

District Health Officer No. 6,

District File Number 1144-1194

Date Filed NOV 17 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.