

1974

S. No. 2
M-5-42
7-5-17-39
W1 X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 14 1945

Registration District No. 63

Primary Registration District No. 4113

Registrar's No.

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

1. PLACE OF DEATH:

(a) County CHARITON

(b) City or town BRUNSWICK 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 1 (Specify whether years, months or days)

In this community 1 years, months or days

3. (a) PRINT FULL NAME SURILDA 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, MARRIED

6. (b) Name of husband or wife GEO. W. DAVIS

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased DEC. 18 1862
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 21 If less than one day hr. min.

9. Birthplace EFFINGHAM ILL I
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business HOUSE WORK

12. Name THOS. H. WHITE

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

14. Maiden name MARY E. BRICKER

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

16. (a) Informant JOHN WHITE

(b) Address MARCELINE MO

17. (a) BURIAL (b) Date thereof 1-11-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BRUNSWICK MO

18. (a) Signature of funeral director [Signature]

(b) Address BRUNSWICK MO

19. (a) 1-11-1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CHARITON

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

(d) Street No. 6
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY Day 9 Year 1945 hour 7 minute A.M.

21. I hereby certify that I attended the deceased from Dec 1944 to Jan 9 1945 that I last saw him alive on Jan 9 1945 and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC FAILURE

Duration 6 MO.

Due to HYPERTENSION

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy

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

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 E. F. Walls (M.D. or other) D.O.
Address Brunswick MO Date signed Jan 20

1024

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Public Health Officer No. 8

2-13-45

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.....

L. N. Gessner

Licensed Embalmer No.....

823

P. O. Address.....

Greenwich, N.Y.

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.

Registration District No. 65

Primary Registration District No. 4113

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Brunswick
(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 Surilda J. 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 m

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

7. Birth date of deceased Dec 18
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 22
If less than one day, hr. _____ min. _____

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

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 _____
(Burial, cremation, or removal) (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 Jan day 19
year 1945 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 _____ Duration _____

mitral stenosis

Due to _____

Due to ar

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

Major findings: **ADDITIONAL, SUPPLEMENTARY INFORMATION REQUESTED**

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 E. F. Walls (M. Deane) DS.

Address Brunswick Date signed Feb 15

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

SUPPLEMENTARY

5-1974