S. No. 2
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

Registration District No. 13

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10143

Primary Registration District No. 3709-4306

Registrar's No.

1. PLACE OF DEATH:

(a) County: McDonald
(b) City or town: Goodman
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: McDonald 60
(c) City or town: Goodman
(If outside city or town limits, write "RURAL")
(d) Street No.: 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: William Eddy Davis

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Margret Davis

6. (c) Age of husband or wife if alive: 67 years

7. Birth date of deceased: April (Month) 6 (Day) 1871 (Year)

8. AGE: Years 73 Months 9 Days 16 If less than one day hr. min.

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

10. Usual occupation: Retired

11. Industry or business:

MOTHER FATHER

12. Name: Ira Eddy Davis

13. Birthplace: (City, town, or county) N.Y. (State or foreign country)

14. Maiden name: Barbra Hasson

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

16. (a) Informant: Margret Davis
(b) Address: Goodman MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-24-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Howard Cemetery

18. (a) Signature of funeral director: Chas W. Williams
(b) Address: Goodman MO.

19. (a) 3/16/45 (Date received local registrar) (b) Mrs C. W. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1945 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 1 to Jan 1, 1945 to Jan 22, 1945 that I last saw him alive on Jan 21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Dilatation — Duration

Due to: Chronic degenerative myocarditis

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations: 0
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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: C. E. Maners (M. D. or coroner)
Address: Date signed:

464

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 345-249
Date Filed MAR 13 1945

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.