

S. No. 2
OM-8-43
v. 5-17-39
I X47823

17180

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 11 1945

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Stone Memorial Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Hosp, 10 Days
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

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

(d) Street No. R.F.D. # 2 Aurora Mo.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Belle Davis

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1945 hour 10 minute 20 P.M.

4. Sex Female 5. Color or race White

6. (a) Name of husband or wife C.L. Davis

6. (b) Single, widowed, married, divorced Married

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Feb, 1 1879
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 17, 1945 to April 30, 1945
that I last saw her alive on April 30, 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

66	3	29	hr. _____ min.
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Immediate cause of death: Central Thrombosis
Respiratory Failure

Due to _____

Due to _____

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

10. Usual occupation Housewife

Other conditions Senility, Arterio Sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 946

11. Industry or business _____

12. Name J.W. Wesley

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

14. Maiden name Theodosi Slandley

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr C.L. Davis

(b) Address R.F.D. # 2 Aurora Mo.

17. (a) Burial (b) Date thereof 5/3/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aurora Mo.

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? _____

18. (c) Signature of funeral director J.P. King

(b) Address Aurora Mo.

19. (a) May-1-1945 (b) Chas. King
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature M.A. Davis (M. D. or other) D.D.

Address Aurora Mo. Date signed 5/1/45

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

49

157

1203

45-5-474

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..... *Ferman Purridge*.....
Licensed Embalmer No. *3072*.....
P. O. Address..... *Aurora 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.