

Registration District No. 43

Primary Registration District No. 2007

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Poplar Bluff Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution few hours
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Thomas F. Davidson

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bridget Davidson 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased July 27 1888
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name W. F. Davidson
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Davidson, son
(b) Address Clarkston, Mo.

17. (a) Burial (b) Date thereof May 16, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanfield

18. (a) Signature of funeral director Lanahan

(b) Address Campbell, Missouri

19. (a) 9-8-45 (b) R. N. Minette
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Clarkston "Rural" is _____
(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 May day 12
year 1945 hour _____ minute 3:20 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death fractured ribs
5-6-7-8-9 left side
Due to heavy hand discharge
phlebotomy
Due to accident happened about 100 yds So. of R.R. crossings at Clarkston, Mo. on Highway 25

Other conditions leucocytosis
(Include pregnancy within 3 months of death)
Major findings: Of operations none Of autopsy none
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) Accident 35
(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? yes (Specify type of place) (e) Means of injury D
23. Signature Th. Henschel (M. D. or other)
Address _____ Date signed _____

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

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.....

Christina M. Landess

Licensed Embalmer No.....

4227

P. O. Address.....

Campbell, MD

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. H 3 Primary Registration District No. 3007

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

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff
(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 (Specify whether _____)
3. (a) PRINT FULL NAME Thomas F. Davidson
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 _____

7. Birth date of deceased July 2 (Month) (Day) (Year)
8. AGE: Years 56 Months 9 Days _____ (If less than one day) _____ min.

9. Birthplace _____ (City, town or county) (State or foreign country) M
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 May year 1945 floor _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____
Due to _____
Other conditions Auto Accident (Include pregnancy within 3 months of death) (collision with truck)
Major findings: Of operations _____
Of autopsy 1700-8-22
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 5-12-45
(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) _____
Date signed 9-9-45

SUPPLEMENTARY

MOTHER FATHER

S-26942