

FILED AUG 18 1945 STANDARD CERTIFICATE OF DEATH

28189

State File No. \_\_\_\_\_

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Pike  
(b) City or town Louisiana  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Pike County Hospital  
(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 Six Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike  
(c) City or town Louisiana  
(If outside city or town limits, write "RURAL")  
(d) Street No. 125 of 3rd St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country No.

3. (a) PRINT FULL NAME William Jordan Davis

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 1 1876  
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Charleville Mo. (U)  
(City, town, or county) (State or foreign country)

10. Usual occupation Medical Doctor

11. Industry or business \_\_\_\_\_

12. Name Jessie D. Davis

13. Birthplace Pike County Mo. (U)  
(City, town, or county) (State or foreign country)

14. Maiden name Julia Coultter

15. Birthplace St. Louis Mo. (U)  
(City, town, or county) (State or foreign country)

16. (a) Informant Jim Davis  
(b) Address Louisiana Mo.

17. (a) Burial (b) Date thereof 7/30/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleville Mo.

18. (a) Signature of funeral director Harner & Harner

(b) Address Louisiana Mo.

19. (a) 7-30-45 (b) J. O. Dalrymple, deputy  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28  
year 1945 hour 4:30 minute PM.

21. I hereby certify that I attended the deceased from 7/12, 1945, to 7/28/45, 1945  
that I last saw him alive on 7/28/45  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 36 hrs

Due to Cirrhosis of the liver Several  
years

Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy no  
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) none  
(b) Date of occurrence none  
(c) Where did injury occur? none  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work? no (Specify type of place) (e) Means of injury no  
23. Signature Charles Jewellon, M.D. (M. D. or other) 7/30/45  
Address Louisiana, Missouri Date signed \_\_\_\_\_

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

2  
2  
1

RECEIVED

District Health Officer No. 10

District File Number 8-45-1323

Date Filed AUG 16 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

*J. B. Stone*

Licensed Embalmer No. 4039

P. O. Address Louisiana, 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.