V. S. No. 2
OM—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED AUG 20 1945

STANDARD CERTIFICATE OF DEATH

State File No. 28686

Registration District No. 340 Primary Registration District No. 4503 Registrar's No. 18

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bernie Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ✓ 1
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard 105
(c) City or town Bernie 1
(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) 0
If yes, name country ✓

3. (a) PRINT FULL NAME Cordelia Davis
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Fem 1
5. Color or race W.
6. (a) Single, widowed, married, divorced Married 1
6. (b) Name of husband or ~~wife~~ John T. Davis
6. (c) Age of husband or wife if alive 82 years
7. Birth date of deceased April (Month) 11 (Day) 1861 (Year)

8. AGE:	Years	Months	Days	If less than one day
	84	3	4	hr. min.

9. Birthplace Indiana (City, town, or county) 1 (State or foreign country)
10. Usual occupation Home wife
11. Industry or business Home
FATHER
12. Name Wm Wilson
13. Birthplace Indiana (City, town, or county) 1 (State or foreign country)
MOTHER
14. Maiden name unknown
15. Birthplace " " (City, town, or county) " (State or foreign country)
16. (a) Informant J. E. Shirel
(b) Address Bernie Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bernie
18. (a) Signature of funeral director Landis Funeral Home
(b) Address Campbell Mo
19. (a) 7-20-45 (Date received local registrar) (b) Cordie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15 year 1945 hour 2 minute 30 - P M.
21. I hereby certify that I attended the deceased from April 29, 1943 to July 14, 1945 that I last saw h. 6 R alive on 7-14-45, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Paralysis Agitans	
Due to	
Due to	
Other conditions Senility (Include pregnancy within 3 months of death)	
Major findings: 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature F O Kelley D.D. (M. D. or other)
Address Bernie Mo Date signed 7/18/45

1123

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 845-1057
Date Filed 8-8-45

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 E. O. Landers

Licensed Embalmer No. 2289

P. O. Address Campbell 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.