S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36468

FILED NOV 30 1945

Registration District No. 1 — Primary Registration District No. 5003 — Registrar's No. 13

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Rural - Morrow Tw.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Near Stahl
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near Stahl
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY FRANCES DAVIS

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

4. Sex F
5. Color or race W
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 10 (Month) 17 (Day) 1936 (Year)

8. AGE: Years 8 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Grundy Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation School Girl
11. Industry or business

FATHER
12. Name Harold Davis
13. Birthplace Adair Co (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Alice Lucille Ishmael
15. Birthplace Adair Co (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Harold Davis
(b) Address Stahl Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Green Castle Cemetery
18. (a) Signature of funeral director Glenn E Kent & Son
(b) Address Green City Mo
19. (a) 10-16-45 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5th year 1945 hour 4 minute 15 P.M.
21. I hereby certify that I attended the deceased from Sept 13 1945, 19 to Oct 15, 1945 that I last saw her alive on Oct 5 1945, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Nephritis	2 weeks
Due to Streptococci Sore	2 weeks
Due to Throat	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy ✓ 1/5 b	

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

23. Signature H P Garrison M.D. (M. D. or other)
Address Mininger Mo Date signed Oct 6 45

1614 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 11-45-1796
Date Filed NOV 27 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Greenville, Ms

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.