

S. No. 2
M-5-43
5-17-39
1 X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37353

State File No. _____

FILED DEC 13 1945

Registration District No. 137

Primary Registration District No. 4222

Registrar's No. 25

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

1. PLACE OF DEATH:

(a) County Holt
(b) City or town Bigelow, Mo
(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 years, months or days)

3. (a) PRINT FULL NAME Clara Delvina Davis

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 1800 years

7. Birth date of deceased Jan 4th, 1800
(Month) (Day) (Year)

8. AGE: Years 79 Months 00 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation House Work.

11. Industry or business _____

MOTHER FATHER

12. Name John Troxel

13. Birthplace Unknown. 9

14. Maiden name Marion Hassinger. 9

15. Birthplace Unknown. 9

16. (a) Informant William Davis

(b) Address Bigelow Mo.

17. (a) Burial (b) Date thereof II/I7/45
(Burial, cremation, or removal) (Month) (Day) (Year)
Craig Mo. IOOF cemetery

18. (a) Signature of funeral director W. G. Crawford
(b) Address Mound City, Mo

19. (a) 1945 (b) J. H. H. H.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 44
(c) City or town Bigelow Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 15
year 1940 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from Aug 1, 1939 to Nov 15, 1940
that I last saw him alive on Nov 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Essential Hypertension Duration 0.2 yr

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none 102

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? no injury
(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 E. J. K. K. K. (M. D. or other) _____

Address 102 E. Main St. M.D. Date signed 11-16-45

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 W. L. Casper

Licensed Embalmer No. 1824

P. O. Address Mount Airy, N.C.

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.