

FILED JAN 14 1946

State File No. _____

Registration District No. 2

Primary Registration District No. 4806

Registrar's No. 2

1. PLACE OF DEATH
 (a) County Andrew
 (b) City or town Fillmore
 (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 70 yrs. years, months or days Wilmon

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Andrew
 (c) City or town Fillmore
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Year or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Ewin Wilmon DAVIS
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 12 day 7
 year 1945 hour 3 minute P. M.
 21. I hereby certify that I attended the deceased from 12-7-1945 to 12-7-1945
 that I last saw him alive on 12-7-1945
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Feb 23 1893
 (Month) (Day) (Year)

Immediate cause of death: Cerebral Apoplexy
 Due to _____
 Due to _____

8. AGE: Years Months Days If less than one day
90 9 14 hr. _____ min.

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy 1
 Duration _____

9. Birthplace Burnham MARIE
 (City, town, or county) (State or foreign country)
 10. Usual occupation Registered Pharmacist

MOTHER FATHER
 11. Industry or business _____
 12. Name CYLUS DAVIS
 13. Birthplace UNKNOWN MARIE
 (City, town, or county) (State or foreign country)
 14. Maiden name Susan Gibson
 15. Birthplace UNKNOWN 9
 (City, town, or county) (State or foreign country)

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?
 While at work? _____ (Specify type of place) (e) Means of injury 1

16. (a) Informant Dr. W. Davis
 (b) Address Fillmore mo
 17. (a) Burial (b) Date thereof 12-9-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Fillmore
 18. (a) Signature of funeral director C. Byers
 (b) Address Lawrence mo
 19. (a) 12-8-45 (b) Fillmore Sparks
 (Date received local registrar) (Registrar's signature)

23. Signature Dr. W. R. Wilson (M. D. or other)
 Address Porendale mo Date signed 12-8-45

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

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 20

Registration District No. 2 Primary Registration District No. 4006

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Fullmoor
(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

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 _____

3. (a) PRINT FULL NAME Ewin W. Davis
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
(b) Name of husband or wife Virginia Davis 6. (c) Age of husband or wife if alive 23
7. Birth date of deceased (Month) Feb (Day) 23 (Year) _____

8. AGE: Years 90 Months _____ Days _____ Unless then one day
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Lillian Sparks (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1941 hour _____ 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 _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

40365