

No. 2
8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 18 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8822**
Registrar's No. **26**

Registration District No. **70**

Primary Registration District No. **5280**

1. PLACE OF DEATH:
(a) County **Clark**
(b) City or town **Ashtown**
(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 **life**
In this community **life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Clark**
(c) City or town **Ashtown**
(If outside city or town limits, write "RURAL")
(d) Street No. **70**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Wilbert Marion Davidson**

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

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

6. (b) Name of husband or wife **Edith Davidson** 6. (c) Age of husband or wife if alive **54** years

7. Birth date of deceased **Aug 7 - 1867**
(Month) (Day) (Year)

8. AGE: Years **78** Months **6** Days **18**
If less than one day hr. min.

9. Birthplace **Ashtown, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

12. Name **James Davidson**

13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Stewart**

15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edith Davidson**
(b) Address **Ashtown, Mo.**

17. (a) **Burial** (b) Date thereof **Feb 27 - 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashtown Co.**

18. (a) Signature of funeral director **Arthur W. Reed**
(b) Address **Kahoka, Mo.**
19. (a) **28-46** (b) **JR Bridges**
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **25**
year **1946** hour **5** minute **00** P.M.

21. I hereby certify that I attended the deceased from **Jan. 1** to **Feb. 25**
that I last saw him alive on **2-21-** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Arterial Sclerosis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **832**
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?

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

23. Signature **JR Bridges** (M. D. or other)
Address **Kahoka, Mo.** Date signed

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

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

RECEIVED

District Health Officer No. 10

District File No. 3-46-521

Date Filed MAR. 16, 1946

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 Oles L. Lutting

Licensed Embalmer No. 2965

P. O. Address Lurray 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.