

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15418

State File No. _____

FILED MAY 27 1946
Registration District No. 376

Primary Registration District No. 6157

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Elle, Rural
(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

3. (a) PRINT FULL NAME Harold Abusted Davis

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased Feb 4 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation me

11. Industry or business me

MOTHER FATHER
12. Name Joe Davis
13. Birthplace Newport Ark
(City, town, or county) (State or foreign country)
14. Maiden name Jessie Clark
15. Birthplace Miss
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joe Davis

(b) Address Levalle

17. (a) Burial (b) Date thereof Mar 31 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dowdy Cem. Deth. Mo

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/30/46 (b) Lottie Jessup
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard
(c) City or town Levalle Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1946 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb 4
1946 to March 30, 1946;
that I last saw him alive on March 23, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death Hydrocephalus Duration _____

Due to _____

Due to _____

Other conditions _____
(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? _____

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

23. Signature Dr. Harold Abusted (M. D. or other) MD

Address Parsons Date signed 3/30/46

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WHITE LINEN—USE UNFADING INK—MAKE A PERMANENT RECORD. I X1931

RECEIVED

District Health Office No. 2

District File Number 546-555

Date Filed 5-4-46

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.