

No 7  
17-39  
X37823

FILED JUN 7 1946

STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Graveson Nursing Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day 6 hrs  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED: Same

(a) State Missouri (b) County Boone

(c) City or town Marshall mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME Thomas J DAVIS.

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th  
year 1946 hour 8 minute 20 A.M.

21. I hereby certify that I attended the deceased from May 8 '46  
\_\_\_\_\_, 19\_\_\_\_, to May 9 '46  
\_\_\_\_\_, 19\_\_\_\_.

that I last saw h in alive on July 9, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer Duration \_\_\_\_\_

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

6. (b) Name of husband or wife Alice L Davis 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 7 1862  
(Month) (Day) (Year)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Infection

(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

83 7 2 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name William Davis

13. Birthplace Dullivan Co Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth M. Major

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

16. (a) Informant Graveson Records

(b) Address Columbia mo

17. (a) Burial (b) Date thereof May 11 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall mo

18. (a) Signature of funeral director R W Campbell

(b) Address Marshall mo

19. (a) 5-11-46 (b) Mrs R E Palmer  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature Geo H Graveson (M. D. or other) \_\_\_\_\_  
Address 1408 University Date signed 5/9/46  
Columbia mo

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

MOTHER FATHER

RECEIVED:

District Health Officer No. 9,

District File Number.....

Date Filed 6-5-46

**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..... *R. W. Campbell*

Licensed Embalmer No. 3469

P. O. Address Marshall, Md

**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. June  
Registrar's No. 106

Registration District No. 28 Primary Registration District No. 2006

1. PLACE OF DEATH:  
(a) County Boone  
(b) City or town Columbia  
(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 Thomas J. Davis  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

8. AGE: Years 80 Months 7 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Iowa (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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from May 8 1946 to May 9 1946 and that death occurred on the date and hour stated above. Immediate cause of death Shock +  
Cocciemia

Due to Malignant ulceration  
Cancerous perforation  
at angle of rt. jaw through Es  
Due to larynx + esophagus  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Duration \_\_\_\_\_

ADDITIONAL PHYSICIAN  
Major findings: This patient  
treated at  
operation  
pressure  
of autops  
of same hospital  
of gross technical  
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 Scott Granace M.D.  
Address 1408 Union Columbia Mo. (M. D. or other) \_\_\_\_\_  
Date signed 6/12/46

14609 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

15717