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FILED OCT 10 1946

Registration District No. 122

Primary Registration District No. 5454

Registrar's No. 24

1. PLACE OF DEATH

(a) County Greene
(b) City or town Pond Creek
(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 25 yrs. (years, months or days)

3. (a) PRINT FULL NAME Mrs. Aseneth Eda 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 married
6. (b) Name of husband or wife Austin Davis 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased June 10 - 1885
(Month) (Day) (Year)

8. AGE: Years 61 Months 3 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James Rogers 9
13. Birthplace unknown!
(City, town, or county) (State or foreign country)
14. Maiden name Aseneth Johnson
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Leona Davis

(b) Address Billinge - Mo. Route

17. (a) Burial (b) Date thereof Sept 29 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wades Chapel

18. (a) Signature of funeral director J. W. Maples

(b) Address Cleves, Mo.

19. (a) 9-28-46 (b) Florence Brittain
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 27
(c) City or town Billinge rural
(If outside city or town limits, write "RURAL")
(d) Street No. Billinge Route 2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27th
year 1946 hour 7 minute 0 A. M.
21. I hereby certify that I attended the deceased from Aug. 5 - 1945
Sept 27 1946 to 8 1946
that I last saw her alive on Sept. 21 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Uterus Duration 2 yrs

Due to _____
Due to _____

Other conditions Diabetes 5 yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations X 870
Of autopsy _____
PHYSICIAN _____

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 0

23. Signature S. M. Clark M.D. (M. D. or other)
Address Halltown Mo. Date signed 9-27-46

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

RECEIVED

Greene County Health Office,

County File Number 46-12-113

Date Filed 10/9/46

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 J.M. Maple

Licensed Embalmer No. 2985

P. O. Address Clever, 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. *act*

Registration District No. *122*

Primary Registration District No. *5454*

Registrar's No. *24*

1. PLACE OF DEATH:

(a) County *Greene*
(b) City or town *Pand ueh*
(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)

3. (a) PRINT FULL NAME *Azeneth E. Davis*

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years *61* Months *3* Days _____ (Unless than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) *Sept. 28, 1946* (b) *Florence Dettman*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1946* 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 _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY 7

30054