

No. 2  
7-8-43  
-17-36  
X-17-223

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 5 1946**  
Registration District No. 361

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

43304

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Primary Registration District No. 6226

1. PLACE OF DEATH:  
(a) County Vernon  
(b) City or town Clayton Eve  
(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 \_\_\_\_\_  
In this community 50 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Vernon  
(c) City or town Clayton Eve  
(If outside city or town limits, write "RURAL")  
(d) Street No. None  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Octavo Davis  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day Unknown  
year 1946 hour unknown minute unknown  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife O. I. Davis 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased October 4, 1946  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Due to been dead for at least 7-10 days  
Due to \_\_\_\_\_  
Duration \_\_\_\_\_

8. AGE: Years 63 Months Unknown Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy no

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Joe Caldwell  
13. Birthplace Cincinnati, Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Josie Blair  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant John A. Caldwell  
(b) Address Nevada, Missouri

17. (a) Burial (b) Date thereof 11-29-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deerfield Mo.  
(c) Signature of funeral director Konantz Mortuary

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 Car

(b) Address Fort Scott, Kansas

19. (a) Dec - 1-46 (b) Betha Single  
(Date received local registrar) (Registrar's signature)

23. Signature Martha C. ... (M. D. or other) \_\_\_\_\_  
Address Nevada, Mo. Date signed 11-25-46

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

OCT 22 1947

No. 38  
1-2-42  
1 X 4328

AL RECORD

RECEIVED  
District Health Officer No. 2  
11-46-3038  
12-7-46

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 *Glen W. Hammors*

Licensed Embalmer No. *4109*

P. O. Address *Ed. Scott, Kansas*

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.

ABLE LVVL

Registration District No. *361*

Primary Registration District No. *6226*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Vernon*  
(b) City or town *Coal twp. Eve*  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)

(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 *Octavo Dawson*

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 *Mar*

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 Months Day If less than one day  
*63* hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) *Beitha Single* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town *Coal twp. Eve* (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 *Jan* day *1* year *1946* hour *1* minute *15* M.

21. I hereby certify that I attended the deceased from *1946* to *1946*

that I last saw him alive on *1946* 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

SUPPLEMENTARY

S-43304