

S. No. 2  
M-8-43  
5-17-39  
P I X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43778

State File No. \_\_\_\_\_

Registrar's No. 18

FILED MAR 25 1947  
Registration District No. 82

Primary Registration District No. 5311

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Rural - Pilot Grove Sup  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution none  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none  
(Specify whether years, months or days)

In this community 37 yrs.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

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

(d) Street No. near Pilot Grove, Mo  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME VERNON-ROGEX-DAVIS

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 14<sup>th</sup> day December  
year 1946 between 4 & 6 min. am. M.

21. I hereby certify that I attended the deceased from no attendance 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race w.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alfreda Davis

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased June - 12 - 1909  
(Month) (Day) (Year)

Immediate cause of death Asphyxiation

Duration \_\_\_\_\_

8. AGE: Years 37 Months 6 Days 2 If less than one day hr. min.

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

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

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

Other conditions (Include pregnancy within 3 months of death) 64 B

10. Usual occupation Farmer

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

11. Industry or business Farmer

Of autopsies Lung filled with water

12. Name John Davis

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

14. Maiden name Miriam Smith

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

16. (a) Informant John S Davis

17. (a) Burial (b) Date thereof 2-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Wayne J. Hunter

19. (a) 2-12-47 (b) W. Cooper  
(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) suicide

(b) Date of occurrence probably Dec 14 - 1946

(c) Where did injury occur Stammillion Lagoon Mo  
(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 W. DeGraffen (M. D. or other) no

Address Portneville Mo Date signed 2/11/47

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

42584

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 3-22-47

APR 1 1947

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 not embalmed

\_\_\_\_\_ Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Leyton E. Mayo

Licensed Embalmer No. 3074

P. O. Address. Pilot Grove Wis.

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.