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17-39  
247070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 28 1947**

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

**9642**

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

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jasper

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

(c) Name of hospital or institution:  
Freeman Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether in this community \_\_\_\_\_ years, months or days)

In this community 57 years  
(years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jasper **49**

(c) City or town Joplin **2**  
(If outside city or town limits, write "RURAL")

(d) Street No. 515 N. Sergeant **5**  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) **0**  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Charles R. Davis

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male **0**

5. Color or race white

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

6. (b) Name of husband or wife Mary Coles Davis

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased November 20 1869  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>77</u>	<u>3</u>	<u>12</u>	_____ hr. _____ min.

9. Birthplace Knox County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Grocer

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

MOTHER FATHER

12. Name Robert H. Davis

13. Birthplace Smithland, Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizbeth Richmond

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

16. (a) Informant Mary Coles Davis

(b) Address 515 N. Sergeant

17. (a) Removal (b) Date thereof March 6, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baxter Springs, Kans

18. (a) Signature of funeral director Hurlbut Und. Co

(b) Address Joplin, Mo.

19. (a) 3-8-47 (b) Ed. O. Johnson  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 4th  
year 1947 hour 11:57 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Jan 25 1947 to 3/4 1947  
that I last saw him alive on 3/4 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial Failure

Due to myocardial Failure

Due to myocardial Failure

Duration  
2 mo. 3 mo.

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: none  
Of operations \_\_\_\_\_

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

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 injury)

While at work \_\_\_\_\_ (e) Cause of injury \_\_\_\_\_

23. Signature Ed. O. Johnson (Reg. D. or other) \_\_\_\_\_

Address Joplin Mo Date 3/2/47

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

138

(Licensed Embalmer's Statement on Reverse Side)

41-3-708

JUL 19 1948

JUL 5 1948

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 Ferry K. Luedbeck

Licensed Embalmer No. 959

P. O. Address Josephine Hill

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..

Registration District No. 156 Primary Registration District No. 201

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Joplin  
(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

Charles R. 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 m

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

7. Birth date of deceased Nov 20 1920  
(Month) (Day) (Year)

8. AGE: Years 77 Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day) hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (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)

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 Mar year 1947 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 \_\_\_\_\_

Due to \_\_\_\_\_  
Due to chronic hepatitis  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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. Mitchell \_\_\_\_\_ (for other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

9642

