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No. 2
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-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 17 1947

Registration District No. 199

Primary Registration District No. 5732

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon
(b) City or town South Effard
(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 Missouri (b) County Macon 61
(c) City or town South Effard 3
(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 _____

3. (a) PRINT FULL NAME ERNEST CECIL DAVIS

3. (b) If veteran, name war World War II
3. (c) Social Security No. 707-07-7485

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March - 30 - 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 11 20 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name William W. Davis

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

14. Maiden name Carie M. Sharr

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

16. (a) Informant Carie M. Davis

(b) Address South Effard Mo.

17. (a) Burial (b) Date thereof 3-25-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Indian Hill

18. (a) Signature of funeral director J. R. McCallum

(b) Address South Effard, Mo.

19. (a) Mar 31 - 1947 (b) Daphne Stewart
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 22
year 1947 hour 6 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 Shot self in head with 22 long rifle - INSTANT DEATH.

Due to BULLET ENTERED HEAD ABOUT 1 INCH ABOVE RIGHT EAR

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) Suicide

(b) Date of occurrence 3-22-47

(c) Where did injury occur Effard Macon Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
IN EARL SHED NEAR HOME

While at work? NO (Specify type of place) (e) Means of injury Shot self

23. Signature W. L. Edwards (M. For State)

Address 13 Wiles, Mo. Date signed 3/24/47

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

MOTHER FATHER

1289

(Licensed Embalmer's Statement on Reverse Side)

MAR 20 1953

RECEIVED
District Health Officer No. 10
District File Number # 7-219
Date Filed -- APR. 15. 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *A. N. McCallum*

Licensed Embalmer No. 2052

P. O. Address South Gifford, 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.