

S. No. 2  
M-5-43  
v. 5-17-39  
I X36671

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

FILED JUN 2 3 1947

Primary Registration District No. 6268

Registrar's No. 33

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

1. PLACE OF DEATH:

(a) County Webster

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

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

(d) Length of stay: In hospital or institution x  
(Specify whether)

In this community life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster <sup>112</sup>

(c) City or town Nianqua <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. x <sup>0</sup>  
(If rural, give location)

(e) Citizen of foreign country? No <sup>0</sup>  
If yes, name country x (Yes or No)

3. (a) PRINT FULL NAME Lewis H. Davison

3. (b) If veteran, name war x

3. (c) Social Security No. x

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Wula A. Davison

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

7. Birth date of deceased Sept. -- 7 - 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1, 1947 to May 3, 1947  
that I last saw alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. 19

8. AGE: Years Months Days If less than one day

79 7 26 x hr. x min.

Immediate cause of death Asphyxia

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

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

9. Birthplace Missouri <sup>0</sup>  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name John H. Davison

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

14. Maiden name Susan Ragsdale

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. O. H. Cardwell (daugh.)

(b) Address Marshfield, Mo.

17. (a) Burial (b) Date thereof 5/5/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Pleasant View

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? \_\_\_\_\_

18. (a) Signature of funeral director W. F. Schmitt

(b) Address Marshfield, Mo.

19. (a) 5-12-47 (b) W. F. Schmitt  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury 0

23. Signature W. F. Schmitt (M. D. or other) 0  
Address Nianqua Date signed May 12 1947

RECEIVED

District Health Officer No. 6;

District File Number 547-548

Date Filed MAY 22 1947

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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 Rex Rainey

Licensed Embalmer No. 312

P. O. Address Marshfield, 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.