

FILED AUG 1 1947 390

Registration District No. Primary Registration District No. 4442

Registrar's No.

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Higbee Mo
(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 About fifty years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph 88
(c) City or town Higbee Mo
(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.

3. (a) PRINT FULL NAME Mrs Gertrude Davies

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive, years
7. Birth date of deceased: Dec 12 1891
(Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days 11 If less than one day .hr. .min.

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

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER { 12. Name James Bailey 9
13. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)
14. Maiden name Dont Know
15. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Davies
(b) Address Higbee Mo

17. (a) Burial (b) Date thereof June 26 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cem. Higbee Mo.

18. (a) Signature of funeral director Joe W. Burton
(b) Address Higbee Mo

19. (a) 6-25-47 (b) J. W. Winn
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1947 hour 10 minute 0 a. M.

21. I hereby certify that I attended the deceased from 1 May 1945 to 26 June 1947
that I last saw him alive on 26 June 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Senescia anemia 2 yr
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 J. W. Winn (M. D. or other)
Address Higbee Mo Date signed 6/24/47

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

RECEIVED
District Health Officer No. 10
District File Number 7-47-949
Date Filed JUL 30 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 *E. W. Drummond*

Licensed Embalmer No. *3978*

P. O. Address *Glasgow, 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.

Registration District No. 390

Primary Registration District No. 7222

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Higley
(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 Gertrude Davis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 Dec 12
(Month) (Day) (Year)

8. AGE: Years 55 Months _____ Days _____ (If less than one day) _____
hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

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) 6-25-47 (Date received local registrar) J. H. [Signature] (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 _____ year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, at _____, Mo., and that death occurred on the date and hour stated above. (Immediate cause of death)

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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 _____

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

SUPPLEMENTARY

S-25094