

Registration District No. **58**

Primary Registration District No. **4087**

Registrar's No. **28**

**1. PLACE OF DEATH:**  
 (a) County **Careter**  
 (b) City or town **Van Buren**  
(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 **Life**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo.** (b) County **Carter**  
 (c) City or town **Van Buren**  
(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** **William E. Dorris**  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Oct** day **10**  
 year **1947** hour **11** minutes **30** M.  
**21. I hereby certify that I attended the deceased from** **4-1** 19**47** to **10-10** 19**47**  
 that I last saw him alive on **9-15** 19**47**  
 and that death occurred on the date and hour stated above.

4. Sex **MO** 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **Harry Dorris**  
 6. (c) Age of husband or wife if alive **62** years  
 7. Birth date of deceased **Jan 19 1874**  
(Month) (Day) (Year)

Duration  
**Acute Circulatory Failure - 3 wks.**  
 Due to **Carcinoma of Liver, Nephritis & Chronic Myocarditis.**  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**8. AGE:** Years **73** Months **8** Days **21**  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**HOF**

9. Birthplace **ILL.** /  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** **Timber Worker**

**11. Industry or business**  
**12. Name** **Spivy, Dorris**  
**13. Birthplace** **ILL.** /  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Sarah Jane Williams**  
**15. Birthplace** **ILL.** /  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Mary Dusenberry**  
**(b) Address** **Ellington Mo.**  
**17. (a)** **Burial** **(b) Date thereof** **10-12-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Brame Cemetery**

**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** **Phil A. Leuckel**  
**(b) Address** **Van Buren Mo.**  
**19. (a)** **10-12-47** **(b) Mrs. Oida Henson**  
(Date received local) (Registrar's signature)

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury  
**23. Signature** **Frank J. Rusinski** **(M. D. or other)** **D.O.**  
**Address** **Van Buren, Mo** **Date signed** **10-12-47**

RECEIVED

District

District

Date Filed

Major No. 6,  
1047620  
10-30-47

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 10-11-4

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

Signed Phil A. Leuchter  
Licensed Embalmer No. 2936  
P. O. Address Van Buren

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1102  
Registrar's No. 28

Registration District No. 58

Primary Registration District No. 4087

1. PLACE OF DEATH:

(a) County Carter  
(b) City or town Van Buren  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME

William E 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 \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 73 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

15. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) Oct. 12-47 Mrs Oeta Hensow (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 Oct 1947 year, \_\_\_\_\_ 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 \_\_\_\_\_ 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

33913