

No. 2
12-45
17-39
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40644**

FILED DEC 15 1947

Registration District No. **37**

Primary Registration District No. **3075**

Registrar's No. **97**

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(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 Stoddard / 03

(c) City or town Dexter / 3
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) / 1

(e) Citizen of foreign country? _____ (Yes or No) / 0
If yes, name country _____

3. (a) PRINT FULL NAME Arthur George Davis

3. (b) If veteran, name war _____

3. (c) Social Security No. 331-01-3153

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1947 hour 4 minute 20 A.M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Edith Wagoner Davis

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Feb. 22, 1895
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 10 - 1947
to Nov 20 1947

that I last saw him alive on Nov 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>8</u>	<u>28</u>	hr. _____ min. _____

Due to My pertusion / 7-8 yrs

Due to Cerebral Vascular Disease / 7-8 yrs

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

9. Birthplace Boston Mass.
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name Adrain Davis

13. Birthplace England / 4
(City, town, or county) (State or foreign country)

14. Maiden name Amanda L. Olson
(City, town, or county) (State or foreign country)

15. Birthplace Sweden / 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edith Davis

(b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 11-22-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter 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 Strickland-Rainey
Dexter, Missouri

(b) Address _____

19. (a) 12/1-1947 (b) Margaret Pruitt
(Date received local registrar) (Registrar's signature) / 12/7

23. Signature Paul J. ... (M. D. or other) _____
Address Dexter Mo Date signed 11/22/47

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

DEC 17 1947

RECEIVED

District Health Office No. 2

District File Number 1247-1560

Date Filed 12-8-47

JUN 15 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 _____

Licensed Embalmer No. 3179

P. O. Address Dexter, 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. 341 Primary Registration District No. 0075

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Depler
(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
years, months or days)

In this community
years, months or days

3. (a) PRINT FULL NAME Arthur G 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 Jul 22 1922
(Month) (Day) (Year)

8. AGE: Years 52 Months Days If less than one day hr. min.

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

10. Usual occupation ENGINEER
 11. Industry or business CATERPILLAR TRACTOR CO

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) (Burial, cremation, or removal) (b) Date thereof (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 Day Year 1942 hour minute 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

Due to
 Due to
 Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations
 Of autopsy

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) (c) Means of injury

23. Signature (M. D. or other)
 Address Date signed

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

SUPPLEMENTARY

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

48044