. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 7 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42186

Registration District No. 171 Primary Registration District No. 5637 Registrar's No. 4

1. PLACE OF DEATH:
(a) County Lafayette Twps. Clay
(b) City or town Bates City (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3 mi South West
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 25 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lafayette 54
(c) City or town Bates City (Rural) 0
(If outside city or town limits, write "RURAL")
(d) Street No. 3 mi South west 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Frank R Davis

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

4. Sex M O
5. Color or race W
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 May (Month) 2 (Day) 1870 (Year)

8. AGE:

Years	Months	Days	If less than one day
77	0	25	hr. min.

9. Birthplace Copaspring (City, town, or county) W. Va (State or foreign country)
10. Usual occupation
11. Industry or business Farmer
FATHER
12. Name John W Davis
13. Birthplace [illegible] (City, town, or county) W. Va (State or foreign country)
MOTHER
14. Maiden name Lydia Spaid
15. Birthplace (City, town, or county) W. Va (State or foreign country)
16. (a) Informant Mrs M. E. Catron
(b) Address Lexington MO
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 29-47 (Month) (Day) (Year)
(c) Place: burial or cremation Winchester Va
18. (a) Signature of funeral director Mrs J B Webb & Son
(b) Address Oak Grove Mo
19. (a) June 1, 1947 (Date received local registrar) (b) Letta Drummond (Registrar's signature) 152

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 27 year 1947 hour 10:30 A minute M.
21. I hereby certify that I attended the deceased from called as acting coroner, 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 natural causes Probably Coronary Occlusion

Due to attack / severe pain, sweating pain, my left chest. Died before Due to doctor arrived.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature W Martin MD (M. D. or other)
Address Odessa Mo Date signed 5/27/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 1-5-48

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 R B Webb

Licensed Embalmer No. 2353

P. O. Address Blue Springs 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.