

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25662**

FILED SEP 14 1948

Registration District No. **3010**

Primary Registration District No. **3010**

Registrar's No. **276**

1. PLACE OF DEATH:

(a) County **Cape Girardeau**
(b) City or town **Cape Girardeau**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Do East Mo Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 days**
In this community **50 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ill** (b) County **Union**
(c) City or town **Anna Ill 999**
(If outside city or town limits, write "RURAL")
(d) Street No. **110**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) **2**
If yes, name country _____

3. (a) PRINT FULL NAME

Jacob F. Davault

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male**

5. Color or race **W**

6. (a) ~~Single~~, widowed, ~~married~~, divorced **1**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: **Sept 3 1868**
(Month) (Day) (Year)

8. AGE: Years **80** Months **-** Days **-** If less than one day hr. min.

9. Birthplace: **Douglas Ill**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Farmer**

11. Industry or business: **Retired**

MOTHER FATHER

12. Name: **Daniel C. Davault**

13. Birthplace: **Unknown**

14. Maiden name: **Christine Davault**

15. Birthplace: **Unknown**

16. (a) Informant: **Mrs. H. G. Day Hansen**

(b) Address: **1978 Southern Memphis, Tenn**

17. (a) **Burial** (b) Date thereof: **Sept 16 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Anna Ill**

18. (a) Signature of funeral director: **Harris Funeral Home**

(b) Address: **Anna Ill**

19. (a) **9-6-48** (b) **C. C. Summers**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **3rd** year **1948** hour **3** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **July 16, 1948**, to **Sept 3, 1948**; that I last saw him alive on **Sept 3, 1948**; and that death occurred on the date and hour stated above.

Immediate cause of death: **Circulatory Failure**
Due to: **Coronary artery Disease**

Other conditions: **Prostatic Hypertrophy 15 yrs.**

Major findings: **Prostatic Hypertrophy and chronic Cystitis**
Of autopsy: **11/10**

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? _____

23. Signature: **Charles F. Wilson** (M. D. or other) **M.D.**
Address: **727 Broadway** Date signed: **9-7-48**

RECEIVED

District Health Officer No. 4

District File Number 948-116

Date Filed 9-13-4

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

Joseph B. Moos

Licensed Embalmer No. 4750

P. O. Address Anna, Ill

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.