No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

# MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 29609

FILED SEP 20 1948

Registration District No. 71 Primary Registration District No. 3025 Registrar's No. 30

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 2 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Howell 46
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. Mace Ave 5
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Horace Hiram 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 Wid
6. (b) Name of husband or wife Ella Davis
6. (c) Age of husband or wife if alive deceased
7. Birth date of deceased 4-9-1877 (Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days 5 If less than one day hr. min.

9. Birthplace Jasper Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name Jno Davis
13. Birthplace Unk (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Ernest Davis
(b) Address West Plains, Mo.
17. (a) R (Burial, cremation, or removal) (b) Date thereof 7-16-48 (Month) (Day) (Year)
(c) Place: burial or cremation Neely
18. (a) Signature of funeral director Robertson
(b) Address West Plains Mo
19. (a) Sept 8-48 (Date received local registrar) (b) Beatrice Cook (Registrar's signature) 279

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 14 year 1948 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h..... alive on ..... 19...; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death 410 ga. shotgun wounds into right side of face and head. | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy 164C | |

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) suicide 111
(b) Date of occurrence July 14, 1948 11
(c) Where did injury occur? West Plains, Howell, Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? in home. (Specify type of place)
While at work? no (e) Means of injury shotgun 2

23. Signature Mayme C. Thornburg Coroner
Address West Plains, Mo. Date signed 8/12/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Thornburg

RECEIVED 9-13-48
District Health Officer No. 5,
District File Number 94859
Date Filed 9-14-48

## 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 L. L. Roberts

Licensed Embalmer No. 3437

P. O. Address West Ham Me

**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.**

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 30

**1. PLACE OF DEATH:**

(a) County Howell

(b) City or town West Plains
(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)

**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

3. (a) PRINT FULL NAME Horace H. 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 widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased April 9, 1877
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July 14
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| 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?
(Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY

S 29609 1948