

FILED JUL 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24359

BIRTH NO. _____ REG. DIST. NO. 279 PRIMARY REG. DIST. NO. 21415 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pike	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarksville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarksville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Kentucky Street		d. STREET ADDRESS (If rural, give location) Kentucky Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Fannie	b. (Middle) Isabella	c. (Last) Davidson	4. DATE OF DEATH (Month) (Day) (Year) July 19 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 23, 1869	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 5	IF UNDER 1 YEAR Days 26	IF UNDER 1 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housekeeping	11. BIRTHPLACE (State or foreign country) Pike Co., Missouri	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME James McCloud	13b. MOTHER'S MAIDEN NAME Susan Sheppard	14. NAME OF HUSBAND OR WIFE Wm. Edgar Davidson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Sue Ella Melton	ADDRESS Clarksville, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cardiac Asthria</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 19, 1949, to July 19, 1949, that I last saw the deceased alive on July 19, 1949, and that death occurred at 3:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>C. B. ...</i>	23b. ADDRESS Clarksville, Mo.	23c. DATE SIGNED July 20, 1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/21/49	24c. NAME OF CEMETERY OR CREMATORY CLARKSVILLE	24d. LOCATION (City, town, or county) Clarksville Missouri
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DATE REC'D BY LOCAL REG. 7-21-49	REGISTRAR'S SIGNATURE <i>Sudra ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE Garner & Sterne--Louisiana, Missouri	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED JUL 25 1949
District Health Officer
District File Number 7-4
Date Filed JUL 25 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. B. Sterne

Licensed Embalmer No. 4039

P. O. Address Louisiana, 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.