

FILED DEC 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

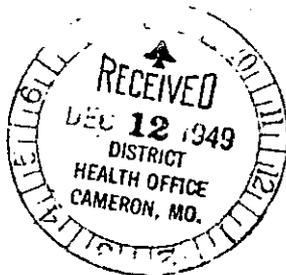
State File No. **40885**

BIRTH NO. _____ REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **3021** Registrar's No. **160**

40, 2

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

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission!) a. STATE MISSOURI b. COUNTY Grundy	
b. CITY (If outside corporate limits, write RURAL and give town) TRENTON		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN TRENTON	
c. LENGTH OF STAY (In this place) 2 yrs		d. STREET ADDRESS (If rural, give location) 304 Linin SX	
d. FULL NAME OF HOSPITAL OR INSTITUTION MULLERS HOSP			
3. NAME OF DECEASED (Type or Print) a. (First) ALBERT		b. (Middle) M.	c. (Last) DAVIDSON
4. DATE OF DEATH (Month) (Day) (Year) 11-13-49			
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar 3, 1863
9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 0 Days 10	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (State or foreign country) Harrison County MO
12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME JEFFITH-DAVIDSON		13b. MOTHER'S MAIDEN NAME SARA SHAW	14. NAME OF HUSBAND OR WIFE Sarah Davidson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Earl M. Davidson ADDRESS Brunn MO
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Vesico-Renal infection ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertrophy of prostate gland DUE TO (c) devenalys II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION Oct. 23-49		19b. MAJOR FINDINGS OF OPERATION Pus and blood in bladder	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
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?
22. I hereby certify that I attended the deceased from Oct 23, 1949 , to Nov 13, 1949 , that I last saw the deceased alive on 11-13, 1949 , and that death occurred at 11:59 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE A. Mullers (Degree or title) MD		23b. ADDRESS Trenton, Mo.	23c. DATE SIGNED 11-14-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-14-49	24c. NAME OF CEMETERY OR CREMATORY Willie Chapel	24d. LOCATION (City, town, or county) (State) Brunn Co. MO
DATE REC'D BY LOCAL REG. 11-14-49		REGISTRAR'S SIGNATURE Drene J. [unclear]	25. FUNERAL DIRECTOR'S SIGNATURE Raymond [unclear] ADDRESS



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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed

Licensed Embalmer No. 3424

P. O. Address Jrento 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.