

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1729

BIRTH NO. _____ REG. DIST. NO. 199 PRIMARY REG. DIST. NO. 5132 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gifford		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gifford	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) Carrie	b. (Middle) May	c. (Last) Davis	4. DATE OF DEATH (Month) (Day) (Year) January 16 1950
-------------------------------------	--------------------------	------------------------	------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH December 29 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 0	IF UNDER 12 HRS. Days 18 Hours 18 Min.
----------------------	-------------------------------	---	--	---	---------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri Adair	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	-----------------------------------	---	--

13a. FATHER'S NAME Henry A. Sharr	13b. MOTHER'S MAIDEN NAME Jerusha Elin Smith	14. NAME OF HUSBAND OR WIFE William Davis
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Perl Zimmerman	ADDRESS Waywood 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 10 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			321X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)	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 **Dec 5, 1949**, to **Jan 16, 1950**, that I last saw the deceased alive on **Jan 16, 1950**, and that death occurred at **7:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE U. T. Woods, D.O.	(Degree or title)	23b. ADDRESS Kirksville, Mo	23c. DATE SIGNED Jan 17, 1950
---	-------------------	------------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE January 18-50	24c. NAME OF CEMETERY OR CREMATORY Indian Hill	24d. LOCATION (City, town, or county) (State) Adair Mo
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. 1-19-1950	REGISTRAR'S SIGNATURE Daphne Hower	194	25. FUNERAL DIRECTOR'S SIGNATURE Th. H. McCall	ADDRESS South Gifford
---	---	-----	---	------------------------------

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

0610
/

RECEIVED 1/23/50
MACON COUNTY HEALTH DEPARTMENT
County File No. 159/15
Date Filed 1/28/50

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 *Clyde M. Callum*
Licensed Embalmer No. 3226

P. O. Address South Gifford 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.