FILED JUL 31 1950

. No. 300
. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22911

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 5135 Registrar's No. 293

1. PLACE OF DEATH a. COUNTY Butler	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Butler
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fisk Rural Ash Hill c. LENGTH OF STAY (in this place)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fisk Rural Ash Hill 0120
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) Willie	b. (Middle) Dea	c. (Last) Davidson	4. DATE OF DEATH (Month) June (Day) 23 (Year) 1950
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 14 1907	9. AGE (In years last birthday) 42 — IF UNDER 1 YEAR Months 7 Days 8 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME John F. Aker	13b. MOTHER'S MAIDEN NAME Florence Wilson	14. NAME OF HUSBAND OR WIFE Deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Loraine Davidson	ADDRESS Fisk, 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) Starvation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Malignancy of stomach
DUE TO (c) & colon

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 151X

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

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) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1950, *to* June 23 1950, *that I last saw the deceased alive on* June 27, 1950 *and that death occurred at* 8 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE F. S. Scillings (Degree or title) Do	23b. ADDRESS Fisk Mo	23c. DATE SIGNED 6/27/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 25, 1950	24c. NAME OF CEMETERY OR CREMATORY Ash Hill Cemetery	24d. LOCATION (City, town, or county) (State) Ash Hill, Mo.
DATE REC'D BY LOCAL REG. July 17-1950	REGISTRAR'S SIGNATURE Wm. H. Johnson 428	25. FUNERAL DIRECTOR'S SIGNATURE Shelby Funeral Home	ADDRESS Fisk Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
JUL 27 1950
BUTLER CO. HEALTH CENTER
FILE No. 750-315

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 E Shuetland

Licensed Embalmer No. 3779

P. O. Address Dexter, 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.