

FILED JAN 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3648

BIRTH NO. _____ REG. DIST. NO. 375 PRIMARY REG. DIST. NO. 6288 Registrar's No. 4

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

3. NAME OF DECEASED (Type or Print) a. (First) Andrew b. (Middle) Jackson c. (Last) Davis			4. DATE OF DEATH (Month) (Day) (Year) Jan. 20, 1951		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Sept. 16 1861			9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician
11. BIRTHPLACE (State or foreign country) Mahaska County Iowa			12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Abner Davis		13b. MOTHER'S MAIDEN NAME Matilda Whittaker		14. NAME OF HUSBAND OR WIFE X	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Cooper Grove Springs, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar Pneumonia</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>495X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
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 Jan 13, 1951, to Jan 20, 1951, that I last saw the deceased alive on Jan 21, 1951, and that death occurred at 5:20a m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Grove Springs, Mo</u>		23c. DATE SIGNED <u>Jan 24, 1951</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/24/51		24c. NAME OF CEMETERY OR CREMATORY Jones Cemetery	
				24d. LOCATION (City, town, or county) (State) S. of Nixa, Missouri	

DATE REC'D BY LOCAL REG. 1-24-1951		REGISTRAR'S SIGNATURE <u>[Signature]</u> 546		25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer ADDRESS Springfield, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JAN 28 1931
WRIGHT CO. HEALTH DEPT.
County File Number 137-7
Date Filed Jan 27 1931

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 *Walter E Hametta*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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.