

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29225**

FILED SEP 11 1953

BIRTH NO. _____ REG. DIST. NO. **181** PRIMARY REG. DIST. NO. **5675** Registrar's No. **32**

1. PLACE OF DEATH a. COUNTY LINCOLN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY LINCOLN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - HURRICANE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL HURRICANE TWP	
c. LENGTH OF STAY (in this place) 68 yrs		d. STREET ADDRESS (If rural, give location) NORTH LINCOLN CO 570	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) HARRIET b. (Middle) GRANT c. (Last) DAVIS			4. DATE OF DEATH (Month) (Day) (Year) August 18-1953		
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 10-1864		9. AGE (In years last birthday) 88 ^{Months} 9 ^{Days} 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and State or Foreign Country) Lincoln Co., Mo.	
				12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Alfred Rooks		13b. MOTHER'S MAIDEN NAME Henrietta Fife		14. NAME OF HUSBAND OR WIFE George B. Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mabel Wilson, Annada, 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, hydrostatic		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTE-MORTEM CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) congestive heart failure		
	DUE TO (c)		
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 4341		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 checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **8-17**, 19**53**, to **8-18**, 19**53**, that I last saw the deceased alive on **8-17**, 19**53**, and that death occurred at **3:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) med.		23b. ADDRESS ELSPERRY, MO		23c. DATE SIGNED 8/18/53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-20-53		24c. NAME OF CEMETERY OR CREMATORY MILL CREEK CEMETERY		24d. LOCATION (City, town, or county) (State) UNION TOWNSHIP MO.	
DATE REC'D BY LOCAL REG. 9/9/53		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCua Funeral Service Eolia, Mo			

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

590
1

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 _____

George O. Wagner

Licensed Embalmer No. _____

3773

P. O. Address _____

Louisiana, La.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.