

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D FEB 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2023
 Do not use this space.

1. PLACE OF DEATH

(a) County CLAY Registration District No. 201
 (b) Township LIBERTY Primary Registration District No. 5280 Registered No. 7
 (c) City LIBERTY (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOHN DAVIDSON

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF BELLE DAVIDSON
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/30/1864
 7. AGE YEARS 74 MONTHS 4 DAYS 11 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. FARMER
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CLAY CO. MO.

FATHER
 13. NAME A. C. DAVIDSON
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KY.
MOTHER
 15. MAIDEN NAME SALLIE CHANDLER
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO.

17. INFORMANT MRS. BELLE DAVIDSON
 (ADDRESS) LIBERTY MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE LIBERTY MO. DATE 21/11/39

19. FUNERAL DIRECTOR HESEL - CORDER
 (ADDRESS) LIBERTY MO.

20. FILED 11/19/39 19 ET Bran
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) I/11/39. 19

22. I HEREBY CERTIFY that I attended deceased from Jany 11 1939 to Jany 11 1939
 I last saw him alive on Jany 10 1939 Death is said to have occurred on the date stated above, at 3:05 A.M.
 The principal cause of death and related causes of importance were as follows:
Myocardial Degeneration Date of onset _____

Other contributory causes of importance: 93C

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify J. W. Matthews M. D.
 (Signed) _____ (Address) Liberty Mo.

RECEIVED
District Health Officer No. 8
District File Number
7/39
to be Filed

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)