

DEC'D FEB 15 1939

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

2349
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 315
 (b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 87
 (c) City SPRINGFIELD (d) Street No. 903 W Florida St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Thomas Davidson
 (a) Residence, No. 903 W Florida St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 3, 1846
 7. AGE YEARS 92 MONTHS 10 DAYS 24 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Harmer Pitt
 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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27, 1939
 22. I HEREBY CERTIFY That I attended deceased from Jan 17, 1939 to Jan 27, 1939
 Last saw him alive on Jan 27, 1939. Death is said to have occurred on the date stated above, at 10:40 P.M.
 The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peru, Ind.
 13. NAME Levi Davidson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peru, Ind.
 15. MAIDEN NAME Sarah Lamberson
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peru, Ind.
 17. INFORMANT (ADDRESS) Dr. Davidson (son) Springfield, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Rocky Comfort Cem. Jay - 29 - 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin B. Meyer Springfield, Mo.
 20. FILED Jan 29, 1939 Chas. C. George Local Registrar

Other contributory causes of importance:
Chr. Myocarditis
Arteriosclerosis
 Name of operation..... Date of.....
 What test confirmed diagnosis? clinical Was there an autopsy? no
 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? No
 If so, specify.....
 (Signed) Arthur H. Krasch, M. D.
 Address 450 E. Cox St. Springfield, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.