

No. 2
11-10-39
17-59
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14798**

Registration District No. **287**

Primary Registration District No. **5405**

Registrar's No. **8**

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

1. PLACE OF DEATH:

(a) County **Franklin**
(b) City or town **Harnersville, Rural**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Henry H. Davidson**

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Lenora Davidson** 6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **March 4 1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **4** If less than one day _____ hr. _____ min

9. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Ed. Andy Davidson**

13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Waldrop**

15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Luanna Williams**

(b) Address **Harnersville, Mo. Rural**

(c) (d) Date thereof **4-9-40**
(Month) (Day) (Year)

(e) Place: burial or cremation **Harnersville**

18. (a) Signature of funeral director **Emerson Burns**

(b) Address **Harnersville, Mo.**

19. (a) **4/13/40** (b) **L. B. Cape**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Franklin**
(c) City or town **Harnersville, Rural**
(If outside city or town limits write "RURAL")
(d) Street No. **R.M.W. 1m. S.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **8**
year **1940** hour **6** minute _____ P. M.

21. I hereby certify that I attended the deceased from **near**
2 1/2 _____, 19**40** until **Apr 8**, 19**40**
that I last saw him alive on **Apr 8**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hem. Hdc**

Due to **Cardio-renal - Circulatory**

Due to **bronch**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? **Only** (Specify type of place) _____
Means of injury _____

23. Signature **H. L. Cape** (M. D. or other) _____
Address **H-127 L 940** Date signed _____

RECEIVED

District Health Officer No. 2

District File Number 540-97

Date Filed 5/2/40

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 comply with the above constitutes grounds for revocation of license.)

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