

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26442

Registration District No. 810

Primary Registration District No. 4488

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Sealander  
 (b) City or town Memphis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
 (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 20  
(Specify whether)

In this community 13.7  
years, months or days

3. (a) PRINT FULL NAME George F. Davidson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Unkn

6. (b) Name of husband or wife Jennie Davidson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr 9 1862  
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Clark Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Barber

11. Industry or business \_\_\_\_\_

12. Name Don't Know 9

13. Birthplace Don't Know 9  
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know ?

15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

16. (a) Informant George Davidson

(b) Address Memphis, Mo

17. (a) Rural (b) Date thereof July 9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memphis, Mo

18. (a) Signature of funeral director Fritz Backert

(b) Address Memphis, Mo

19. (a) July 13-40 (b) E. E. Farnish  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sealander  
 (c) City or town Memphis, Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th  
 year 1940 hour 5:15 minute 15 P.M.

21. I hereby certify that I attended the deceased from July-21  
 1938, to July-7, 1940  
 that I last saw him alive on July 7-1, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis  
 Due to Carcinoma of lymph glands of neck  
 of neck 2 yrs

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?  
725  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature P. M. Browning (M. D. or other) DO.  
 Address Memphis, Mo Date signed 7-10-40

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

19  
20

3 Browning  
26442

46

RECEIVED

District Health Officer No. 10

District File Number 8-40-1663

Date Filed AUG 19 1940

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26442**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **810**

Primary Registration District No. **4488**

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County **Scotland**  
(b) City or town **Memphis**  
(If outside city or town limits, write "RURAL" and name of township)  
(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 **Geo F Davidson**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years **78** Months **2** Days **29** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7**  
year **1946** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Myo Carditis** Duration \_\_\_\_\_

**Carcinoma of lymphatic glands & Dis. Bone ?**  
**but side ? neck**

Other conditions \_\_\_\_\_ # **N. M. D.** #  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ **5/8**

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

