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FILED OCT 18 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33379

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 226

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Burns, Washington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp # 3 Nevada Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 wks, 24 days
(Specify whether)

In this community unknown.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Douglas

(c) City or town Arva
(If outside city or town limits, write "RURAL")

(d) Street No. unknown
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Warren C. Davis

3. (b) If veteran, name war unknown 3. (c) Social Security No. no

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

6. (b) Name of husband or wife Julie Davis 6. (c) Age of husband or wife if alive unknown

7. Birth date of deceased Nov 14 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>9</u>	<u>18</u>	hr. _____ min.

9. Birthplace Nevada MO
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business 0

MOTHER FATHER

12. Name Simmon Davis

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

14. Maiden name Sarah E. Garrison

15. Birthplace unknown MO
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record (b) Address Nevada Mo.

17. (a) Burial (b) Date thereof Sept 6th 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hosp Cemetery

18. (a) Signature of funeral director Allen V. Harp (b) Address Nevada Missouri

19. (a) Sept 3 1940 (b) Allen V Harp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 2
year 1940 11. hour 20 minute P M.

21. I hereby certify that I attended the deceased from 5-8-1 1940 to 9-2 1940
that I last saw him alive on 9-2 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis and chronic nephritis

Due to _____

Due to _____

Other conditions 7/8
(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? 795
(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 A. Borg (M. D. or other) MD
Address State Hosp # 3 Date signed 9/3/40

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

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1429

Date Filed 10-8-40

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 Allen V. Karp

Licensed Embalmer No. 1968

P. O. Address Nevada Mo

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.