No. 2
-2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 14 1944

Registration District No. 38

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3006

State File No. 21045

Registrar's No. 159

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: 505 W. Blvd. S.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether in this community 20 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10

(c) City or town Columbia 2
(If outside city or town limits, write "RURAL") 4

(d) Street No. 505 W. Blvd. S.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME JENNIE DAVIDSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Albert H. Davidson

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 7 - 21 - 1855 (Month) (Day) (Year)

8. AGE: Years 88 | Months 11 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Savannah (City, town, or county) Georgia (State or foreign country) 1

10. Usual occupation At Home

11. Industry or business .....

FATHER
12. Name Antonio Ponce
13. Birthplace ..... (City, town, or county) Spain (State or foreign country) 5

MOTHER
14. Maiden name Elizabeth Kite
15. Birthplace ..... (City, town, or county) England (State or foreign country) 4

16. (a) Informant Mrs. I.O. Hockaday

(b) Address 505 W. Blvd. S., Columbia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-44 (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia, Mo.

19. (a) 6-29-44 (Date received local registrar) (b) Edna Barlow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1944 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan 1st, 1944, to June 27th, 1944, that I last saw her alive on June 27th, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to age and resulting arterio-sclerosis

Due to .....

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature [signature] (M. D. or other) 4

Address Columbia Date signed 6/29/44

250

(Licensed Embalmer's Statement on Reverse Side)

JUL 18 1944

RECEIVED
District Health Officer No. 9,

District File Number .....

Date Filed .....

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. W. D. McKitrick

Licensed Embalmer No. 3893

P. O. Address Columbia, M

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

If this body is not embalmed, fact should be so stated above.

No. 2B
I—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 38 Primary Registration District No. 3086 Registrar's No. 15-9

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia
(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 years, months or days) In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Jerome Davidson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: July (Month) 21 (Day) 1855 (Year)

8. AGE: Years 88 Months 11 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Georgia (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 27 year 1944 hour 1 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.

	Duration
Immediate cause of death: Uremia	
Interstitial nephritis	
Due to: Age X resulting	
arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

13/a

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

23. Signature: [illegible] (M. D. or other)
Address: Columbia Date signed 7/15/44

SUPPLEMENTARY

21045