V. S. No. 2
50M—5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 27 1944

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41127

Primary Registration District No. 2000

Registrar's No. 892

1. PLACE OF DEATH:

(a) County: GREENE

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

(c) Name of hospital or institution: 312 ½ E. COMMERCIAL ST. (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO. (b) County: GREENE

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

(d) Street No.: 312 ½ E. Com'l. (If rural, give location)

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

If yes, name country: W

3. (a) PRINT FULL NAME: ORIE W. DAVIS

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: MALE O

5. Color or race: WHITE

6. (a) Single, widowed, married, divorced: WIDOWER

6. (b) Name of husband or wife: UNK.

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

7. Birth date of deceased: Dec. (Month) 25 (Day) 1868 (Year)

8. AGE: Years 75 Months 11 Days 13 If less than one day hr. min.

9. Birthplace: Cedar Co. (City, town, or county) MO. (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business: Farming

MOTHER FATHER

12. Name: George G. Davis

13. Birthplace: Unk. (City, town, or county) Unknown (State or foreign country)

14. Maiden name: Minnie Fleeman

15. Birthplace: Unk. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Mrs. Ora Lanford

(b) Address: Greenfield MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13-1944 (Month) (Day) (Year)

(c) Place: burial or cremation: Bethel, Kan

18. (a) Signature of funeral director: J. W. Klingner & Co.

(b) Address: SPRINGFIELD MO.

19. (a) 12-13-44 (Date received local registrar) (b) R. W. T. Hoadley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7 year 1944 hour 11:00 minute P. M.

21. I hereby certify that I attended the deceased from: Dec 7 physician, 19..., to attendance, 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	
Due to:	
Due to:	
Other conditions: Malnutrition (Include pregnancy within 3 months of death)	
Major findings: Of operations: 9 3 d	PHYSICIAN
Of autopsy:	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? (c) Means of injury:

23. Signature: [illegible] C. Stone (M. D. or other)

Address: Springfield Mo. Date signed 12-12-44

(Licensed Embalmer's Statement on Reverse Side)

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.....J B Klinger.....

Licensed Embalmer No.....3358.....

P. O. Address.....Springfield 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, fact should be so stated above.