

FILED FEB 8 1945
Registration District No. 324

Primary Registration District No. 6092

State File No. _____

Registrar's No. 3

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Saline County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline
(c) City or town Marshall Rural
(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 Charles Boyden Davis
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 15
year 1945 hour 4 minute 15 P. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Minnie Jones Davis
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from June 1 1945 to June 1 1945
(that I last saw him alive on June 30 1945 and that death occurred on the date and hour stated above.)

7. Birth date of deceased July 25 1871
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis & compensation
Duration 7

8. AGE: Years 73 Months 5 Days 6 If less than one day _____ hr. _____ min.

Due to _____
Due to _____

9. Birthplace Saline county Missouri
(City, town, or county) (State or foreign country)

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

10. Usual occupation Produce dealer & farming

Major findings: Of operations _____ Of autopsy _____

11. Industry or business _____

12. Name John B. Davis

13. Birthplace Saline county Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sallie E. Smith

15. Birthplace Saline county Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Minnie Davis
(b) Address Napton, Mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof Jan. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nelson, Mo.

18. (a) Signature of funeral director Camp Lee Davis
(b) Address Marshall, Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

19. (a) 1-16-45 (b) _____
(Date received local registrar) (Registrar's signature)

(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 John B. Davis (M. D. or other) _____
Address Marshall Mo. Date signed 1/2/45

RECEIVED

District Health Officer No. _____

Set File Number _____

Filed _____

2-7-57

FEB 10 1945

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, ~~either~~ _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Jan. N. Davis

Licensed Embalmer No. 1171

P.O. Address Marshall 770

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.

Registration District No. 324

Primary Registration District No. 6092

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Rural Grandpass, 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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Charles B. Davis

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 W

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

7. Birth date of deceased July 25 (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days _____ Unless than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo

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) T.O. Westwood Reg. (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____ Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____
Due to _____

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

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____

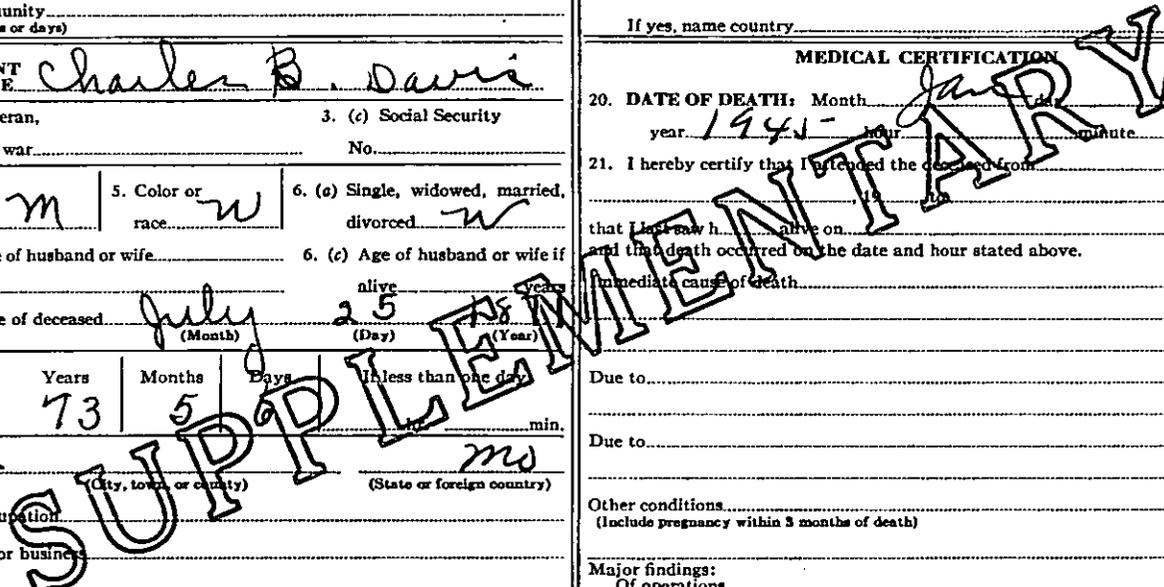
Underline the cause to which death should be charged statistically.

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? _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____



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

3702