DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 8 1945

Registration District No. 373

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6270

State File No.

Registrar's No. 2

**1. PLACE OF DEATH:**

(a) County Webster

(b) City or town Rural-Union [illegible]
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether
In this community 43 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Webster

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

(d) Street No. Union township
(If rural, give location)

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

3. (a) PRINT FULL NAME Margaret Ann Davis

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William P. Davis

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

7. Birth date of deceased February - 24 - 1861
(Month) (Day) (Year)

8. AGE: Years 83 | Months 10 | Days 2 | If less than one day X hr. X min.

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

10. Usual occupation Housewife

11. Industry or business Home

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

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

16. (a) Informant's own signature Mrs. W. F. Keesling
(b) Address Conway, Missouri.

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-29-44
(Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Rader, Missouri.

18. (a) Signature of funeral director [illegible]
(b) Address Marshfield, Missouri.

19. (a) Jan. 18-45 (Date received local registrar) (b) Charlotte Bruce (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month December day 26
year 1944 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from Dec 1 — 1944, to Dec 26, 1944
that I last saw her alive on Dec 26, 1944
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Chronic Constitutive | |
| Due to Nephritis | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 131a | |
| 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature W F Schmidt (M. D. or other)
Address Niangua Date signed 1-5-45

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED
District Health Officer No. 6,
Number 245-166
Date Filed FEB 6 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, or by ——— ———, Registered Apprentice No. ———, working under my personal supervision.

Signed Lex Lainey

Licensed Embalmer No. 3312

P. O. Address Marshfield 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.**