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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 6 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 142

Primary Registration District No. 5556

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether

In this community 17 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46

(c) City or town Mountain View, Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 0
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Walter R. Davis

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Grace V. Davis

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased April 16th 1897
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st
year 1945 hour 7 minute P M.

21. I hereby certify that I attended the deceased from March 6, 1945 to July 30, 1945
that I last saw him alive on July 30, 1945
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>3</u>	<u>15</u>	hr. _____ min.

Immediate cause of death Coronary Heart Failure

Due to mitral lesion

Due to _____

Other conditions Carcinoma of Neck
(Include pregnancy within 3 months of death)

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Tom Davis

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

14. Maiden name Jane Chitwood

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

Major findings:
Of operations _____

Of autopsy 059

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

16. (a) Informant Grace V. Davis

(b) Address Mountain View, Mo

17. (a) Burial (b) Date thereof Aug 2, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain View, MO

18. (a) Signature of funeral director John F. Brown

(b) Address Mountain View, Mo

19. (a) 8-15-45 (b) Laura Mitchell
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury

23. Signature Stanley Bannister (M. D. or other) DO

Address Mountain View Date signed 8-11-45

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

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

John F. Stinson

Licensed Embalmer No. *2516*

P. O. Address

Mountain View W

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept 190
Registrar's No. _____

Registration District No. 142

Primary Registration District No. (3386)

1. PLACE OF DEATH:

(a) County Hannibal

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

(c) Name of hospital or institution Rural
(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

3. (a) PRINT FULL NAME Walter P. 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 m

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

7. Birth date of deceased Apr 16
(Month) (Day) (Year)

8. AGE: Years 48 Months 3 Days 4 If less than one day _____ hr. _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(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 _____ Year 1948 (hour) _____ minute _____ M.

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

Immediate cause of death _____

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)

(e) Means of injury _____

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

SUPPLEMENTARY

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

S-27501