

FILED MAY 9 2 1946

Registration District No. _____

Primary Registration District No. 5382

State File No. _____

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Rural; Earnest township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6 miles No. of Lockwood /
(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 80 years
years, months or days)

3. (a) PRINT FULL NAME CATHERINE M. DAVIS

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife W. T. Davis 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 16 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 10 5 hr. _____ min.

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

10. Usual occupation Home

11. Industry or business Home

MOTHER FATHER { 12. Name Nicholas McGuire
13. Birthplace Tennessee /
(City, town, or county) (State or foreign country)
14. Maiden name Armelia Johnson
15. Birthplace Tennessee /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Osa Cole
(b) Address Lockwood, Missouri.
17. (a) Burial (b) Date thereof 4-23-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenfield, Missouri

18. (a) Signature of funeral director Sam E. Senseney Jr.
(b) Address Greenfield, Mo
19. (a) 4-26-1946 (b) Geo. L. Weir
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29
(c) City or town GREENFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. 211 So. Main 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
year 1946 hour 9 minute 05 P. M.

21. I hereby certify that I attended the deceased from 4-1 1946, to 4-18 1946
that I last saw her alive on 4-18 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Malignancy of Stomach

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: _____
Of operations _____
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?

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J. D. Combs (M. D. or other) _____
Address Lockwood, Mo Date signed 4-24-46

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 Sam E. Senesney

Licensed Embalmer No. 4099

P. O. Address Shunfield, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. Ma

Registration District No. 13

Primary Registration District No. 5332

Registrar's No. 350

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Rural
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Catherine M Davis
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 wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 80 Months _____ Days _____ (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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (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 _____

20. DATE OF DEATH: Month April year 1946 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 _____

Duration _____
In my opinion Cancer there was no X Ray or Autopsy

Due to _____
Due to _____

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

Major findings: Of operations _____
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? _____

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

23. Signature T.D. Combs (M. D. or other) _____
Address Lockwood Mo Date signed 5-12-46

SUPPLEMENTARY

12085