

FILED SEP 10 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 170

Primary Registration District No. 5636

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town RURAL WASHINGTON TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CONWAY RT. 2. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: _____ (Specify whether
In this community 40 YRS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53
(c) City or town: Conway Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME EDGAR DAVISON

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife EMMA WILLIAMS 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased NOV 8 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 9 15 hr. min.

9. Birthplace DANAS CO MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name GOSHIA DAVISON
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name NOT KNOWN
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant ROY DAVISON

(b) Address SPRINGFIELD MO

17. (a) BURIAL (b) Date thereof 8-25-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARLIN CEM.

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO

19. (a) Aug 31, 1946 (b) One Frankenburg
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 23RD
year 1946 hour 6 minute 45 PM

21. I hereby certify that I attended the deceased from 8-23 1946 to 8-23 1946
that I last saw him alive on 8-23 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage of brain
Due to Hypertension

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations §30
Of autopsy _____

Duration
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 11

23. Signature J. W. Lindsey (M. D. or other) MD
Address Conway Mo Date signed 8-25-46

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

Received 7-5-46

Laclede County Health Unit

File No. 8-46-126

Date Filed 9-5-46

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..... *W. A. Palmer*

Licensed Embalmer No. *1161*

P. O. Address *Lebanon, 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.

Registration District No. 170 Primary Registration District No. 5636

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

1. PLACE OF DEATH:

(a) County Laclede

(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 Edgar Davison

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 _____

7. Birth date of deceased Nov. 8
(Month) (Day) (Year)

8. AGE: Years 72 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct 5, 1946 (b) Orin Frankenberg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Laclede

(c) City or town Conway 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 23
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 _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

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