

## FILED OCT 23 1946 STANDARD CERTIFICATE OF DEATH

State File No. 788

Registration District No. 128

Primary Registration District No. 2000

Registrar's No.

## 1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Springfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Burge O  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
 (Specify whether years, months or days)

## 3. (a) PRINT FULL NAME

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

4. Sex M O 5. Color or race W.  
 6. (a) Single, widowed, married, divorced ✓  
 6. (b) Name of husband or wife.....  
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Feb. 1 1853  
 (Month) (Day) (Year)

8. AGE: ✓ Years 93 Months 8 Days 0 If less than one day hr. min.

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

10. Usual occupation Stock man

## 11. Industry or business

12. Name Joshua Davison  
 13. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace.....  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lee Wallace

(b) Address R R #1 Springfield, Mo.

17. (a) Burial (b) Date thereof 10-3-1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wiley Park

18. (e) Signature of funeral director W Klingner Co.

(b) Address Springfield, Mo.

19. (a) 10-3-46 (b) W H Hensley MD  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39  
 (c) City or town Springfield O.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R.F.D. #1 O.  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1  
 year 1946 hour 3 minute 40 A. M.

21. I hereby certify that I attended the deceased from 9-22-46, 19... to 10-1-46, 19...  
 that I last saw him alive on 9-30-46, 19...  
 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Rt. Hip  
Generalized Atherosclerosis  
 Duration 8 days

Due to.....

Due to Senility

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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)..... 133

(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 [Signature] (M. D. or other) O

Address Springfield, Mo. Date signed 10/1/46

**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 *Max Hodus*  
4071  
Licensed Embalmer No.....  
P. O. Address.....  
*Springfield*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**  
**If this body is not embalmed, fact should be so stated above.**

X

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
(a) County Greene  
(b) City or town Springfield  
(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 Thomas M. Dawson  
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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Feb. 1 (Month) (Day) (Year)

8. AGE: Years 93 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Tenn

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 Oct Day 1 Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ 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 \_\_\_\_\_  
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) Fract. Rt. Hip  
(b) Date of occurrence 9-22-46  
(c) Where did injury occur? Springfield, Mo (City of town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Fall in Room  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo Date signed 10-29-46

SUPPLEMENTARY

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

32086

33258