

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 6 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **4168**  
Registrar's No. **78**

Registration District No. **47** Primary Registration District No. **3008**

1. PLACE OF DEATH:  
(a) County **Callaway**  
(b) City or town **Fulton**  
(c) Name of hospital or institution: **Callaway County Hospital (1)**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: **19 Years** **75 Days**  
In this community **19 Years**  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **COVIE DAVIS**  
(b) If veteran, name war.....  
(c) Social Security No.....

4. Sex **Female**  
5. Color **White**  
6. (a) Single, widowed, married, divorced, **Widowed**  
(b) Name of husband or wife.....  
(c) Age of husband or wife if alive **12** years **1870**  
Birth date of deceased **Oct** (Month) **12** (Day) **1870** (Year)

8. AGE: Years **76** Months **4** Days **11**  
If less than one day hr. min.

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

10. Usual occupation **Housework**

11. Industry or business  
12. Name **William Gathright**  
13. Birthplace **Wainwright Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Tharp**  
15. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Monroe Davis**  
(b) Address **Mokane Missouri**  
17. (a) **Burial** (b) Date thereof **2-25-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Middle River Cemetery**  
18. (a) Signature of funeral director **Hallice Funeral Home**  
(b) Address **776th St Fulton Missouri**  
19. (a) **2-25-1947** (b) **Josie M. Manschaff**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Callaway**  
(c) City or town **Mokane**  
(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 **Feb** day **23rd** year **1947** hour **9** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Nov 21 1946** to **Feb 23rd 1947**  
that I last saw her alive on **Feb 22 1947**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma**  
**of many in pelvis with metastases to bone or pleura**  
Due to **pleura**

Duration **Probably 6 months**  
Due to.....  
Other conditions **55E**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy **No P. 21**  
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 **0**  
23. Signature **W. B. Blues** (M. D. or other) **919**  
Address **Fulton** Date signed **2/24/47**

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed MAR 3 1947

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 *Wenzel C. Browning*  
Licensed Embalmer No. *2724*  
P. O. Address *Fulton md*

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.