

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 194

1. PLACE OF DEATH:

(a) County Cole  
 (b) City or town Jefferson City, Missouri  
 (If outside city or town limits, write "RURAL" and name of locality)  
 (c) Name of hospital or institution:  
Missouri State Prison Hospital 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 42 days  
 In this community 24 yrs. 7 mo. 17 days  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri  
 (b) County Polk 26  
 (c) City or town Red Top, Mo. 5  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ 4  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Ezra Davidson

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

4. Sex Male 0  
 5. Color or race W  
 6. (a) ~~Single~~ Married  
~~widowed~~ 2  
~~divorced~~

6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 23, 1896  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>11</u>	<u>12</u>	_____ hr. _____ min.

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

10. Usual occupation XXXX

11. Industry or business XXXX

12. Name XXX

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

14. Maiden name XXXX

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

16. (a) Informant Prison Hosp Records

(b) Address Jefferson City, Mo.

17. (a) Burial (b) Date thereof Sept-6-1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place, burial or cremation Buffalo, Missouri  
Gordon Funerals

18. (a) Signature of funeral director [Signature]

(b) Address Jefferson City, Missouri

19. (a) 9-5-47 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5  
 year 1947 hour 3:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from July 26  
1947, to Sept 5, 1947;  
 that I last saw him alive on Sept 5, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Uremia  
 Due to Pyelonephritis, chronic  
 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? U

While at work \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature John L. Parkien M.D.  
 Address 102 State Mason Sept 5, 1947  
 (M. D. or other) Date signed

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed SEP 11 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 *Shurp J. Gordon*  
Licensed Embalmer No. *1786*  
P. O. Address *Jefferson City 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. 77 Primary Registration District No. 3016

**1. PLACE OF DEATH:**  
 (a) County cole  
 (b) City or town Jefferson city  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Prison  
 (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)

**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.....

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

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month.....  
 year 1947 hour..... minute..... M.

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 Sept 23  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from..... to....., 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

**8. AGE:** Years 50 Months 4 Days 10 If less than one day.....hr.....min.

Due to.....  
 Due to.....

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

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

10. Usual occupation.....

Major findings:  
 Of operations.....

11. Industry or business.....

Of autopsy.....

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. (c) (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) 9-26-47 (b) R. P. Davis MD  
 (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..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

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

S-30742