FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34889

FILED NOV 7 1947

Registration District No. 770

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dallas 30
(c) City or town Rural (If outside city or town limits, write "RURAL") 0
(d) Street No. Rural Route (If rural, give location) 0 1
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dixie ANN 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct. (Month) 15th (Day) 1947 (Year)

8. AGE: Years — Months — Days 2 If less than one day hr. min.

9. Birthplace Lebanon Mo (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name W. E. Davis
13. Birthplace Webster Co. Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Helen Mae Clark
15. Birthplace Dallas Co. Mo. (City, town, or county) (State or foreign country)
16. (a) Informant W. E. Davis
(b) Address Conway Mo. Rt 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation Harmony Cemetery
18. (a) Signature of funeral director W. E. Holtman
(b) Address Lebanon Mo.
19. (a) Nov 1, 1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17 year 1947 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from 10/15, 1947 to 10/17, 1947 that I last saw her alive on 10/17, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemorrhagic disease	
Due to Newborn	2 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 16 C
Of autopsy

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature James L. Hope M. D. or other
Address Lebanon, Mo. Date signed 10/20/47

Jefferson City Printing Co.

(Licensed Embalmer Statement on Reverse Side)

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

Received 11/5/47

Laclede County Health Unit

File No. 11-47-191

Date Filed 11/5/47

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 No Embalming Registered Apprentice No., working under my personal supervision.

Signed Dorsey M. Howe

Licensed Embalmer No. 4222

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.