

FILED DEC 26 1947
Registration District No. 336

Primary Registration District No. 4521

Registrar's No. 132

1. PLACE OF DEATH:

(a) County TEXAS
(b) City or town HOUSTON Precy
(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 60 years (Specify whether years, months or days)
In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Texas 107
(c) City or town HOUSTON
(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 LUCINDA 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, widowed

6. (b) Name of husband or wife JAMES 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JAN 19 1867 (Month) (Day) (Year)

8. AGE: Years 80 Months 9 Days 25 If less than one day hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER

12. Name MARIAN ELGIN

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

14. Maiden name REBECCA TAYLOR

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

16. (a) Informant Mrs. Charley Fazel (Daughter)

(b) Address Houston, Mo

17. (a) Burial (b) Date thereof Nov 16 - 1947 (Month) (Day) (Year)

(c) Place: burial or cremation HOUSTON

18. (a) Signature of funeral director Gaylord V. Elliott

(b) Address Cabot, Mo

19. (a) Dec. 3, 1947 (b) Myrtie Craig (Registrar's signature) (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 14 year 1947 hour 25 minute P. M.

21. I hereby certify that I attended the deceased from 14-4-40, 19 to 11-14-47, 19 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocardial Regeneration

Duration 2 years

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:

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? 2

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Henry R. Rosey (M. D. or other) D.O.

Address Houston, Mo Date signed 11-15-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

07
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RECEIVED

District Officer No. 5,
District File No. 1247730
Date Filed 12-24-47

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

Signed Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, Tex

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.