

FILED APR 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12850**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 179

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JASPER</b>	
b. CITY OR TOWN <b>JOPLIN</b>		c. CITY OR TOWN <b>JOPLIN</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2111 Sergeant</b>		d. STREET ADDRESS (If rural, give location) <b>2111 Sergeant</b>	
3. NAME OF DECEASED (Type or Print) <b>FRED M. DAVIS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>4 13 49</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 23, 1865</b>
9. AGE (In years last birthday) <b>83</b>		if UNDER 1 YEAR <b>6</b> Months <b>20</b> Days	if UNDER 2 Hrs. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Davis Merc. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Livingston Co., Ky.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Grabiell E. Davis</b>	
13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Katherine Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Katherine Davis, Joplin, Mo.</b>		ADDRESS _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS <b>arterial sclerosis</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>prostatic hypertrophy</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <b>5-12-48</b> , 19 <b>48</b> , to <b>7-28</b> , 19 <b>48</b> , that I last saw the deceased alive on <b>7-28</b> , 19 <b>48</b> and that death occurred <b>many hours</b> from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>J. S. Ramsey M.D.</b>		23b. ADDRESS <b>Joplin, Mo.</b>	
23c. DATE SIGNED <b>4-4-49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>4-15-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Joplin Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Parke r-Hunsaker</b>	
25. ADDRESS <b>Mortuary, Joplin, Mo.</b>		DATE REC'D BY LOCAL REG. <b>4-16-49</b>	

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

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed F. M. Jones

Licensed Embalmer No. 2819

P. O. Address Joplin 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.