WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County: Putnam

Township: Medrain

or Village:

or City: (NO. St.; Ward)

Registration District No. 717

Primary Registration District No. 5946

File No. 20571

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** James E. Davis

**PERSONAL AND STATISTICAL PARTICULARS**

SEX: Male

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

DATE OF BIRTH: June (Month) 14 (Day), 1836 (Year)

AGE: 77 yrs. mos. 5 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 1-02

BIRTHPLACE (City or town, State or foreign country): Clark Co. Ills

PARENTS

NAME OF FATHER: Abraham Davis

BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky

MAIDEN NAME OF MOTHER: Nellie Ellege

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos B. Davis

(ADDRESS) Lucerne Mo

Filed 6-20, 1913. F. D. Rice REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: June (Month) 19 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from June 3, 1913, to June 19, 1913, that I last saw him alive on June 19, 1913 and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Pulmonary Congestion

(Duration) yrs. mos. ds.

(Signed) G. N. Steele M. D.

June 20, 1913 (Address) Lucerne Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Howard Cem.

DATE OF BURIAL: 6/20, 1913

UNDERTAKER: J. Lee Hawk

ADDRESS: Lucerne Mo.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

## MISSOURI STATE BOA
BUREAU OF VITAL
CERTIFICATE OF

**PLACE OF DEATH**

County .....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No

(NO. ....., ..... St.: ..... Ward

**FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|

DATE OF BIRTH ..... (Month) ....., ..... (Day) ....., ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS
- NAME OF FATHER .....
- BIRTHPLACE OF FATHER (City or town, State or foreign country) .....
- MAIDEN NAME OF MOTHER .....
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., .....
REGISTRAR

**MEDICAL CERTIFICATE OF**

DATE OF DEATH ..... (Month)

I HEREBY CERTIFY, that I
....., 191..., to .....
that I last saw h..... alive on .....
and that death occurred, on the date st
The CAUSE OF DEATH* was as follows

.....
.....
.....
..... (Duration) ..... yrs.

Contributory ..... (SECONDARY)
..... (Duration) ..... yrs.

(Signed) .....
....., 191..... (Address) .....

*State the Disease Causing Death, or, in death
(1) Means of Injury; and (2) whether Accidental, Suicid

LENGTH OF RESIDENCE (FOR HOSPITALS, INS RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State .....
Where was disease contracted if not at place of death? .....
Former or usual residence .....

PLACE OF BURIAL OR REMOVAL

UNDERTAKER