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

PLACE OF DEATH

County New Madrid

Township Goodman

or Village

or City Gideon (NO. ____ St.; ____ Ward)

Registration District No. 53 — File No. 25371

Primary Registration District No. 4033 — Registered No. 45 —

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

FULL NAME William A Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	S

DATE OF BIRTH May 24 (Month) (Day) 1913 (Year)

AGE: 2 yrs. 2 mos. 7 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) Gideon Mo

PARENTS

NAME OF FATHER David A Davis

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

MAIDEN NAME OF MOTHER Edna Devine

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D Arnold A Davis

(ADDRESS) ____

Filed 8/6, 1915 M. V. Munsun REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 31 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw h__ alive on ____, 191__, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

We the Jury find that Williams Adams Came to his Death by Natural Cause

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) T A Shaw M D M. D.

191__ (Address) ____

*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	DATE OF BURIAL
St Paul	Aug 1 1915
UNDERTAKER	**ADDRESS**
Oscar Conyers	Gideon

If DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____ St. _____ Ward)

[If death occurred hospital or institu give its NAME i of street and numb

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

_____, 1_____
(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 DEATH

DATE OF DEATH

_____, 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

_____, 191__, to _____, 1

that I last saw h_____ alive on _____, 1

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____

Contributory _____
(SECONDARY)

_____(Duration)_____yrs._____mos._____

(Signed) _____

_____, 191__ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death_____yrs._____mos._____ds. In the State_____yrs._____mos._____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS