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 ~~Bory~~ Barry

Township ~~Wheten~~ Wheaton

or

~~Village~~ Shoal Creek

or

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. ~~[illegible]~~ 31 File No. ~~[illegible]~~ 8846a

Primary Registration District No. 5044 Registered No. 10

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

FULL NAME Jewel Davis

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Child

DATE OF BIRTH: October (Month) 18 (Day), 1920 (Year)

AGE: _____ yrs. 6 mos. 1 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Newton Co Mo

PARENTS

NAME OF FATHER: Paul Davis

BIRTHPLACE OF FATHER (City or town, State or foreign country): Barry ~~Bory~~ CO Mo

MAIDEN NAME OF MOTHER: Caroline Nelson

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Illinois ~~Stutson Cp 811~~

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul Davis

(ADDRESS) Purdy Mo.

Filed June 15/1921 ~~April 20th~~ 1921 A. J. Clevinger ~~[illegible]~~ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 19th (Day) 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from April-10th, 1921, to April-19, 1921, that I last saw her alive on April-18, 1921, and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal
Toxemia

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Otis D. McCall M. D.

~~April 19 1921~~ June 15/1921 (Address) ~~Wheaton 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: Muncy Chapel Barry Co Mo

DATE OF BURIAL: April 20 1921

UNDERTAKER: J. H. White

ADDRESS: Fairview Mo

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

PLACE 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 in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

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.

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

....., 191....
(Month) (Day) (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:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed)..... 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 ....., 191....
UNDERTAKER	ADDRESS