LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

17986

1. PLACE OF DEATH

County: Jasper — Registration District No.: 411 — File No.:

Township: Joplin — Primary Registration District No.: 2082 — Registered No.: 276

City: Joplin Mo. (No. 119 Byers St. Ward)

2. FULL NAME: Fred Wm Davis Sr

(a) Residence. No. 119 Byers St., Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Virgilla G. Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sep 21-1848

7. AGE: Years 76 Months 9 Days 6 If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Salesman

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cleveland Ohio

PARENTS

10. NAME OF FATHER: Joshua L Davis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Va

12. MAIDEN NAME OF MOTHER: Jemima Jackson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): N. C.

14. INFORMANT: Mrs Virgilla Davis (Address) Joplin Mo.

15. FILED: 6/27/1924 Kirsand Clark, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 27 1924

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1924 to June 12, 1924, that I last saw him alive on June 12, 1924, and that death occurred, on the date stated above, at 3-20 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H C Powers, M. D. (Address) Joplin Mo. 6-27-1924

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Forest Park Cem — DATE OF BURIAL: 6-28 1924

20. UNDERTAKER: Humphrey Co. — ADDRESS: Joplin Mo.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

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

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

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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