

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

Do not use this space.

17771

1. PLACE OF DEATH

County Cass
 Township West Peculiar
 City..... (No.)..... St. Ward)

Registration District No. 162
 Primary Registration District No. 5774

File No.
 Registered No.

2. FULL NAME

Elmer George Davis

(a) Residence. No. St. Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-9 1927

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

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... (that I last saw him not under treatment death occurred, on the date stated above, at.....)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 8 1884
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 1 1

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dead suddenly from unknown cause
2 yrs. 12 mos. ds. (duration)

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

CONTRIBUTORY (SECONDARY) 205 B
 (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cass Co., Mo.

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

PARENTS

10. NAME OF FATHER Cyrus Wright Davis
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) East Illinois
 12. MAIDEN NAME OF MOTHER Kate Wright
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

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

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) H. B. Gruley, M. D.
 , 19 (Address) Peculiar Mo

*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.

14. INFORMANT Edmund G. Davis
 (Address) Harrisonville Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wells Cemetery DATE OF BURIAL 19

15. FILED Jun 10 1927 REGISTRAR H. B. Gruley

20. UNDERTAKER Runningburg Bros & Co. ADDRESS Harrisonville Mo.

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

25 1927

SECRET
The information should be kept
SECRET



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Gas Registration District No. 162 File No. _____
 Town Peculiar Primary Registration District No. 5227 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Elma George Davis

(a) Residence. No. _____ 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) M

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 _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

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

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 June 10 1927 J. H. Boush 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 him _____ alive on _____, 19 _____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 _____ (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Willis Cemetery June 11 1927
 20. UNDERTAKER Bennett Bros ADDRESS Harrison

SUPPLEMENTARY

REGISTRATION should be carefully supplied. AGE should be stated EXACTLY. F.S.S. shall be reported in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. COMPLETE AS PRESCRIBED. SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THE REGISTRAR HAS RECEIVED THE SUPPLEMENTARY.

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