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

Do not use this space.

26450

File No. .....
Registered No. 24

1. PLACE OF DEATH
County: Boone
Registration District No.: 172
Primary Registration District No.: 4041
Township: .....
City: Centralia (No. ..... St. ..... Ward)

2. FULL NAME: Dave Martin Davis

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 12-20-1860

7. AGE: Years 66 | Months 8 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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): Callaway Co. Mo

PARENTS
10. NAME OF FATHER: James Davis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Margaret Miller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs Hallie Davis
(Address): Centralia Mo

15. FILED: Sep 5, 1927 J. T. Hickerson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 4th 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to Sept 4, 1927, that I last saw him alive on Sept 4, 1927, and that death occurred, on the date stated above, at 12 30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 2 hours
(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? General Symptoms

(Signed) H. G. White, M. D
Sept 4, 1927 (Address) Centralia 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Centralia Mo Cem
DATE OF BURIAL: Sept 5 1927

20. UNDERTAKER: M. J. McDonald
ADDRESS: Centralia Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.