

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

Do not use this space

30793

1. PLACE OF DEATH

County Howell  
Township Howell  
City Howell (No. ....)

Registration District No. 384  
Primary Registration District No. 535-

File No. 91  
Registered No. ....  
St. .... Ward

2. FULL NAME

Clara Marie 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 13 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

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

10. NAME OF FATHER J. C. Davis

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

12. MAIDEN NAME OF MOTHER Fannie Pallard

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

14. INFORMANT J. C. Davis  
(Address)

15. FILED 10-3-27 O. A. Heinrich  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-2 1927

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:

No doctor is attendance  
Spinal Meningitis  
799 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) HO (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) O. A. Heinrich, D. P., M. D.

103, 1927 (Address) Mt. Pleasant 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 Mt Zion Cem DATE OF BURIAL 10-3-1927

20. UNDERTAKER Allie Rice acting ADDRESS Mt Pleasant Mo

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.

26 1927

