30958-1

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

Do not use this space.

JUN 1 1928

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No. 30958-1

Township Mason — Primary Registration District No. ~~3029~~ — Registered No. 83

City ..... (No. Found in Mississippi River St. ..... Ward)

2. FULL NAME Harry Leslie Davis

(a) Residence. No. Keokuk Iowa St. ..... Ward. Keokuk Iowa
(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 Mary Davis.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 23 - 1906

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
20	10	8	

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

9. BIRTHPLACE (CITY OR TOWN) Mont Rose
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER Geo. Davis.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mont Rose
(STATE OR COUNTRY) Iowa
12. MAIDEN NAME OF MOTHER Hulda Clifton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mont Rose
(STATE OR COUNTRY) Iowa

14. INFORMANT Geo. Davis.
(Address) Keokuk Iowa

15. FILED 4/5 1928 C. E. Stode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 31 1927

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: accidental drowning in Mississippi River

183 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 182 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Chas. R. Scott Coroner M.D.
..... 19 (Address) Marion Co. 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: Keokuk Iowa
DATE OF BURIAL: 1 19

20. UNDERTAKER: Wm M. Smith
ADDRESS: Hannibal

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.

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TH in plain terms, so that it may be properly classified. Exact statement

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Marion — Registration District No. 547 — File No.
Township Mason — Primary Registration District No. 5738 — Registered No. 83
City (No. , St. Ward)

2. FULL NAME Harry Leslie 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: 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
(b) General nature of industry, business, or establishment in which employed (or employer)
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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 4/2 19 28 C E Strode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 1927

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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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL: Nov 2 1928

20. UNDERTAKER: Wm M Smith — ADDRESS: Hannibal

SUPPLEMENTARY

N. B.—Every item ... ted EXACTLY. PHYSICIANS should state CAUSE OF DEATH ... so that it may ... tem. it of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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