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

Do not use this space.

11511

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

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

File No. .....

Registered No. 3354

2. FULL NAME Leonora Davis

(a) Residence. No. 2623 Morgan St., 21 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: Female

4. COLOR OR RACE: Col

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) 9 - 15 - 1891

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(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) Clarksville Mo.

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Laura Nichols

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

14. INFORMANT Mollie Small
(Address) 4201 W. Garfield

15. FILED MAR 25 1928 19.... Mary C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 23 1928

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1928, to March 23, 1928, that I last saw h. alive on March 23, 1928, and that death occurred, on the date stated above, at 4 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Natural insufficiency

92 A (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 900

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Albert Gerhardt, M. D.

, 19.. (Address) St. Louis 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 Clarksville Mo

DATE OF BURIAL March 26 1928

20. UNDERTAKER A. L. Real

ADDRESS 2426 Lucas

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

M. 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.