

JUL 26 1928

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

Do not use this space.

7 21247

1. PLACE OF DEATH

County Marion
Township Neason
City Hannibal

Registration District No. 547
Primary Registration District No. 3029
(No. Herring Hospital)

File No. _____
Registered No. 152
St. _____ Ward _____

2. FULL NAME

Joseph H. Davis
(a) Residence, Box New London R.F.D. 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 Male 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 X X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 20 - 1889

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 6 20

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer 1170
(b) General nature of industry, business, or establishment in which employed (or employer) Farming 59
(c) Name of employer _____ 123

9. BIRTHPLACE (CITY OR TOWN) Rolla Mo.
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER David Davis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Wales

12. MAIDEN NAME OF MOTHER Katherine Stanley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) W.Va.

14. INFORMANT David Davis
(Address) New London R.F.D.

15. FILED 6/12/28 C. E. Stoebe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1928

17. I HEREBY CERTIFY, That I attended deceased from 6-10, 1928 to 5-10, 1928 that I last saw him alive on 6-10, 1928 and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pertussis + Pneumonia
broncho
(duration) yrs. mos. 1 da.

CONTRIBUTORY (SECONDARY) Diabetes Mellitus
+ duodenal ulcer
(duration) yrs. mos. 2 da.

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? Lab.
(Signed) J. H. Handedt, M. D.
, 19 (Address) Hannibal 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. Olivet Cem. DATE OF BURIAL June 11 1928

20. UNDERTAKER Wm. M. Smith ADDRESS Hannibal Mo.

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

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.



1
2
4
3
6