

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

Do not use this space.

30283

**1. PLACE OF DEATH**

County Carroll Registration District No. 136-  
 Township \_\_\_\_\_ Primary Registration District No. 3010  
 City Carrollton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 107

**2. FULL NAME Wm 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-1-1905

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>64.</u>	<u>3</u>	<u>29</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Fremont County  
 (STATE OR COUNTRY) Iowa

10. NAME OF FATHER Samuel Davis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Jane Bernard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Illinois

14. INFORMANT Chas. Davis  
 (Address) Main Station Mo

15. FILED 10/1 1929 Miss E. E. Farnham  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-30 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-1-29, 1929; to 9-30, 1929 that I last saw him alive on 9-29, 1929, and that death occurred, on the date stated above, at 8:30 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Prostatitis, by states  
Pyelo Nephritis  
 (duration) yrs. mos. da. 1 1 1

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (duration) yrs. mos. da. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF BIRTH \_\_\_\_\_

8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) R. M. Press M. D.  
10/1 1929 (Address) Carrollton 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 Keopston Mo DATE OF BURIAL 10/3 1929

20. UNDERTAKER Hilly Bros ADDRESS \_\_\_\_\_

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.

0129  
 022  
 033  
 044

Dr. P. M. Benson  
Camelton, Pa.