

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

Do not use this space.

38115

1. PLACE OF DEATH
 County Ralls Registration District No. 728
 Township Clay Primary Registration District No. 5761
 City Hannibal (No. 3919 West Market) St. _____ Ward _____

2. FULL NAME Ethelyn G. Davis
 (a) Residence No. 3919 W. Market 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.

File No. _____
 Registered No. _____

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 Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18, 1925

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
4 9 12

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

9. BIRTHPLACE (CITY OR TOWN) Oakwood
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Brown Davis

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

12. MAIDEN NAME OF MOTHER Mable Gline

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ralls Co.
 (STATE OR COUNTRY) Missouri

14. INFORMANT Mr. Mable Davis
 (Address) Hannibal Mo.

15. Dec 29 1929 Marvin Sherk
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY that I attended deceased from Oct 29 to Nov 28 1929 and that I last saw her alive on Nov. 28, 1929 and that death occurred, on the date stated above, at 11:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

T. B. Meningitis
2 1/2 About 5 weeks
 (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? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory

(Signed) E. S. Szymmer M. D.
12/21 1929 (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 Hydesburg Mo. DATE OF BURIAL Dec 1 1929

20. UNDERTAKER Mrs M. Smith ADDRESS Hannibal Mo.

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.

