

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

Do not use this space.

1. PLACE OF DEATH

County Wayne Registration District No. 590
 Township St. Francis Primary Registration District No. 2529
 City Greenville (No. _____) St. _____ Ward _____

15771-A

2. FULL NAME

(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 12 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A. Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 1 1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 3 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
 (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) Tennessee

10. NAME OF FATHER Robinson

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

12. MAIDEN NAME OF MOTHER D.K.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) I.K.

14. INFORMANT Roxie Davis
 (Address) Springfield, Mo.

15. FILED 4/17 1930 A. S. Templeton
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 16 - 1930

17. I HEREBY CERTIFY That I attended deceased from Feb 1930 to April 16 1930
 that I last saw h. ea. alive on April 15, 1930 and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

CONTRIBUTORY (SECONDARY) 129a (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? _____

(Signed) Jos F. Woquet, M. D.
4-16-30 address Greenville, 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 Shook Cemetery DATE OF BURIAL 4/18, 1930
 20. UNDERTAKER Gates Undt. Co. ADDRESS Piedmont

K. 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.

25 1930

