

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

Do not use this space.

35826

1. PLACE OF DEATH

County..... *Greene*
Township..... *Republic*
City..... (No.) St. Ward

Registration District No. *317*
Primary Registration District No. *6436*

File No.
Registered No.
St. Ward

2. FULL NAME *Arby E 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

male

4. COLOR OR RACE

white

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

married

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

Logie Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 29-1894*

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>35</i>	<i>10</i>	<i>3</i>	

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)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

James Davis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Rebecca Pearce

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14. INFORMANT

Floyd Little
(Address)

15. FILED

11/30 W.W. Shover
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 2 1930*

17.

I HEREBY CERTIFY, That I attended deceased from

19....., to 19....., and that I last saw him *dead* *Nov 2*, 19*30*, and that death occurred, on the date stated above, at *2:30 a.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Automobile accident
Struck by car while changing tire.
Crushed chest. B.P. 0*
(duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY)

no physician in attendance
(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Humay C. Stone, Coroner, M. D.*

Nov 2, 1930 (Address) Springfield, 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

DATE OF BURIAL

Wise Hill

Nov. 4 1930

20. UNDERTAKER

ADDRESS

J.W. Maples

Clevers Mo

N. B. - Cause of Death must be stated in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is necessary and important.

DEC 22 1930

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 317 File No. _____
 Township Republic Primary Registration District No. 3426 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>35</u>	<u>10</u>	<u>3</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____
 (Address) _____

15.

FILED 11/4 1930 W. S. Hoover
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Auto accident - struck by car while changing tire - crushed chest - on highway - CONTRIBUTORY (60-13) about 2 miles north + 1 mile east of Republic

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address)

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

N. B. - Every item of information should be carefully supplied. AGENT should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in detail. If death is properly classified. Exact statement of OCCASION is very important. REGISTERS BY LAW

SUPPLEMENTARY

S-35826