

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

Do not use this space.

5351

1. PLACE OF DEATH
 61 County Macon Registration District No. 534
 8 Township _____ Primary Registration District No. 4319
 1 City New Center (No. _____) St. _____ (Ward _____)
 2. FULL NAME Marry Jane 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 534
 St. _____ (Ward _____)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 John Davis
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 9-1863
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 10 17
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housekeeper
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ 235
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New York (STATE OR COUNTRY) 2
 10. NAME OF FATHER John Morris
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wales (STATE OR COUNTRY) 8
 12. MAIDEN NAME OF MOTHER Jane Evans
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wales (STATE OR COUNTRY) _____

14. INFORMANT John Davis
 (Address) New Center Mo
 15. FILED 2-27-1932 G. T. Lunday
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 26 1932
 17. I HEREBY CERTIFY, That I attended deceased from July 28, 1930 Feb 25, 1932
 that I last saw him alive on Feb 25, 1932, and that death occurred, on the date stated above, at 2:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ascending Paratyphoid
OIA
 (duration) 2 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 _____
 WAS THERE AN AUTOPSY? no 1
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Ed. West, M. D.

*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 New Center Mo DATE OF BURIAL Feb 28 1932
 20. UNDERTAKER J. E. Gillebrew ADDRESS New Center 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.
 MAR 24 1932

