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

Do not use this space.

9799

File No. .....

Registered No. 3

1. PLACE OF DEATH

93 County St Clair Registration District No. 764

Township Monegaw Primary Registration District No. 6008

City Monegaw Springs ..... St. ..... Ward)

2. FULL NAME Goedie Mabel 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.

APR 29 1932

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

## 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 L. E. Davis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-15-1913

7. AGE 18 YEARS 10 MONTHS 20 DAYS If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 1445
(c) Name of employer 1445

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Camden County Mo

PARENTS

10. NAME OF FATHER Joseph Barnes

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

12. MAIDEN NAME OF MOTHER Martha Reed

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

14. INFORMANT Joseph Davis
(Address)

15. FILED Mar 9, 1932 George Alexander
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5 1932

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Post Partum Hemorrhage
1445
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Child birth
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED (5)
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) F. R. Sullivan, M. D.
, 19 (Address) Conner

No Attendant
Physician
Hemorrhage after birth
Not seen by Dr

*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 Mt Zion Cemetery

DATE OF BURIAL 3-6 1932

20. UNDERTAKER J B Goodrich

ADDRESS Raymondville