

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.

JAN 5 1933

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

Do not use this space.

34384

1. PLACE OF DEATH *Saline*
 97 County *Saline* Registration District No. *794*
 3 Township *Gillian* Primary Registration District No. *4475-*
 City *Gillian* (No. *4475-* St. *4* Ward) (If nonresident, give city or town and State)

2. FULL NAME *James Albert Davis*
 (a) Residence *Saline* St. *4* Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 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 *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 *Sarah Davis*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 17 - 1864*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 3 17

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Restraunt*
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Business*

10. Date deceased last worked at this occupation (month and year) *Indiana 2* 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana 2*

FATHER 13. NAME *Joseph Davis*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

MOTHER 15. MAIDEN NAME *Caroline Dennis*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Saline Mo*

17. INFORMANT *Sarah M. Davis*
 (ADDRESS) *Gillian Mo*

18. BURIAL, CREMATION OR REMOVAL PLACE *Saline Mo* DATE *Oct 6 - 1932*

19. UNDERTAKER *Jones & Salzer*
 (ADDRESS) *Saline Mo*

20. FILED *Oct 15 1932* *J. J. Anderson* Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 4 - 1932*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 12th*, 1932, to *Oct 4th*, 1932.
 I last saw him alive on *Oct 4th* 1932. Death is said to have occurred on the date stated above, at *7:30 P.M.*
 The principal cause of death and related causes of importance were as follows:
Acute Indigestion
1180/118
 Other contributory causes of importance: *Billiousness* (1)
 Name of operation Date of
 What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: -
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) *A. L. Gilliam* M. D.
 (Address) *Gillian Mo*

Date of onset *10-4-32*

