

REC'D AUG 25 1938

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

25820
Do not miss this space.

1. PLACE OF DEATH

(a) County Jimm Registration District No. 506
(b) Township Baker Primary Registration District No. 5671 Registered No. _____
(c) City New Boston (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. J. L. Davis 120 St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Martha P. Davis
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 7 1874
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 64 6 13
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. postmaster
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20 1938
22. I HEREBY CERTIFY, That I attended deceased from 11:30, 1938, to 7:20, 1938. I last saw him alive on 7/20, 1938. Death is said to have occurred on the date stated above, at 3 p.m.
The principal cause of death and related causes of importance were as follows:

Angina Pectoris
121

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
13. NAME William Davis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Boston Mo
15. MAIDEN NAME Anna M. Hartz
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania
17. INFORMANT (ADDRESS) Anna M. Hartzstrom

Other contributory causes of importance:
Chronic Myocarditis
Chronic Nephritis

18. BURIAL, CREMATION, OR REMOVAL PLACE New Boston Mo DATE July 22 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. M. E. Collins & Sons South Linn St
20. FILED _____ 19 _____ Local Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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? No
If so, specify _____
(Signed) D. G. Spear, M. D.
(Address) Bushkin, Mo.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed/Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25829
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 506
 (b) Township Baller Primary Registration District No. 3671
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jacob Lawrence Davis

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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.
64 6 13

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year).....
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7-20, 1938 J. L. Davis Local Registrar.
by A. D. Threlkorn

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 20, 1938

22. I HEREBY CERTIFY, That I attended deceased from, to, 19...
 I last saw h..... alive on, 19... Death is said to have occurred on the date recited above, at..... m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

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) N. C. Greear M.D.
 (Address) Bucelin mo

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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