

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.

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

Do not use this space.

1939 FEB 21 1939

1. PLACE OF DEATH

County Buchanan
Township
City St. Joseph

Registration District No. _____
Primary Registration District No. _____
(No. 102) State Hospital #2

File No. 1692
Registered No. 99
St. _____ Ward _____

2. FULL NAME

Joseph Davis
(a) Residence No. 1352 Bellevue St., _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| | | | | |
|--|---|---|--|--|
| 3. SEX <u>M</u> | 4. COLOR OR RACE <u>W</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u> | | |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Unknown</u> | | | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 30 1857</u> | | | | |
| 7. AGE YEARS <u>81</u> | MONTHS <u>3</u> | DAYS <u>28</u> | If LESS than 1 day, _____ hrs. or _____ min. | |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Fireman</u> | | | |
| | 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>St Joseph fire Dept</u> | | | |
| | 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) Charleston, W. Virg

| | |
|--|---|
| MOTHER | 13. NAME <u>Louis Davis</u> |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>West. Virg</u> |
| | 15. MAIDEN NAME <u>Sarah Selby</u> |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u> | |

17. INFORMANT (ADDRESS) Mo State Hosp #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Ashland Cemetery Jan 30 1939

19. UNDERTAKER (ADDRESS) Barry-Wylie Funeral Home
219 South 10th St

20. FILED Jan 30 1939 A. H. Scoble Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28 1939
22. I HEREBY CERTIFY, That I attended deceased from Nov 16 1937 to Jan 28 1939
I last saw him alive on Jan 28 1939 Death is said to have occurred on the date stated above, at 1 P. m.

The principal cause of death and related causes of importance were as follows:
Cellulitis of Left Arm. (Staphylococcus infection) 1939
General Arteriosclerosis 2 yrs
Senility +

Other contributory causes of importance: _____
Name of operation None 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? No
If so, specify _____
(Signed) E. E. DeLang M. D.
(Address) State Hospital

STATEMENT BY LICENSED EMBALMER

I, D. E. Ryan, Licensed Embalmer No. 3613
hereby certify that the body recorded on the reverse side of this
Certificate was embalmed by Me

or by _____, Registered Apprentice No. _____

(Signed) D. E. Ryan
Licensed Embalmer No. 3613

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