

REC'D APR 13 1939

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

12075
Do not use this space.

Wesper

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 257
 (b) Township St. Charles Primary Registration District No. 3036 Registered No. 30
 (c) City St. Charles (d) Street No. St. Joseph Hospital 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 Mark Bernard Davis

(a) Residence, No. 719 217 E. St. Charles Mo. (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14th 1936

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 7 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 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) St. Charles Mo.

FATHER 13. NAME Mark August Davis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bondou N. Dakota

MOTHER 15. MAIDEN NAME Mrs. Dorothy De Roy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles Mo.

17. INFORMANT (ADDRESS) Mark August Davis St. Charles Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bourbonno Cem. DATE March 7th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. P. J. G. Meyer St. Charles Mo.

20. FILED 3/6 1939 Clarence B. Mueller Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 4th 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1938, to March 4, 1939

I last saw him alive on March 4, 1939. Death is said to have occurred on the date stated above, at 12 P. M.
 The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia ✓
 Date of onset 2-27-39

Other contributory causes of importance:
 Name of operation no 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? no Date of injury
 Where did injury occur? no (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) Raymond G. Gasser, M. D.
St. Charles 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.

1972

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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
HEALTH CARE REGULATORY DIVISION
1972

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

12075-
Do not use this space.

1. PLACE OF DEATH
 (a) County St Charles Registration District No. 757
 (b) Township _____ Primary Registration District No. 3036
 (c) City St Charles (d) Street No. _____ Registered No. _____
 (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 Mark Bernard 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 S
 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. 2 7 20
 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) _____
 MOTHER FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4 1979
 22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Bacterial Pneumonia Date of onset 10/70
cannot state whether there were any complications or not.
 Other contributory causes of importance _____
I had just pulled the twins through pneumonia 2 months previous & think the main complication was lack of a balance or
 Name of operation _____
 What test _____? _____ 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) Raymond G. Cooper, M. D.
 (Address) St Charles Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 N. B.—Every item of information should be carefully supplied. A GS should be stated EXACTLY AS IT OCCURRED. Exact statement of OCCURRENCE is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Local Registrar.

