

REC'D SEP 15 1939

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

30429

Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 868
(b) Township St. Louis Primary Registration District No. 6149 Registered No. 24
(c) City St. Louis (d) Street 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

1700 Asor 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 9, 1870

7. AGE YEARS 69 MONTHS 6 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year) Sept. 1936 11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known N.C.

FATHER 13. NAME Joseph Haves

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known N.C.

MOTHER 15. MAIDEN NAME Christina Roof

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known N.C.

17. INFORMANT (ADDRESS) M. G. Davis Hickory Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Shofer Cema DATE Aug 8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith Ferguson Hickory Mo

20. FILED 8/8 1939 J. J. Reed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 7 1939

I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1939 to Aug 7, 1939

I last saw him alive on Aug 1, 1939 Death is said

to have occurred on the date stated above, at 12:45 pm.

The principal cause of death and related causes of importance were as follows:

Chronic Nephritis Date of onset 1936

Other contributory causes of importance: Arteriosclerosis 1937

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? _____

If so, specify _____

(Signed) J. J. Reed, M. D.

176 (Address) Hickory Mo

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.

RECEIVED

District Health Officer No. 6,

District File Number 939194

Date Filed 9/11/39

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.