

NOV 24 1939

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

35995
Do not use this space.

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 289
(b) Township Wotton Hill Primary Registration District No. 5707
(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 Catherine 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Rosevelt Davis
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 24, 1922
7. AGE YEARS 17 MONTHS 0 DAYS 17 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. Own home
10. Date deceased last worked at this occupation (month and year) Sept 7, 1939 11. Total time (years) spent in this occupation 2 yrs

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

FATHER 13. NAME Samuel Reed

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Rosa Talley

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) J. E. Gardner #2 Parma Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Webb Miss DATE 9/17/1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Cambell Undertaking
Indora Miss

20. FILED 9/13/39 19 39 S. E. Mitchell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 13th 19 39

22. I HEREBY CERTIFY, that I attended deceased from Sept 7th 1939 to Sept 13th 1939
I last saw her alive on Sept 12, 1939 Death is said to have occurred on the date stated above, at 2 a.m.
The principal cause of death and related causes of importance were as follows:

Typhoid fever
Date of onset 9/24/39

Other contributory causes of importance: Intestinal Hemorrhage 9/11/39

Name of operation none Date of _____
What test confirmed diagnosis? clinical as 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 _____, 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 no
Nature of injury _____

24. Was (injury or) death related to occupation of deceased? no
If so, specify _____
(Signed) S. E. Mitchell, M. D.
(Address) Malden Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

FORM-9-19-38 I X16603

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.

RECEIVED

District Health Officer No. 3

District File Number 1189 - 648

Date Filed 11-7-39

OCT 1 1953

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.