

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

Do not use this space.

**FILED MAR 7-1940**

**1. PLACE OF DEATH**

County Madison Registration District No. 232  
Township Johnston Primary Registration District No. 5712  
City (No. ....) (St. ....) (Ward)

File No. 7308  
Registered No. ....

**2. FULL NAME**

Nancy Ann Davis  
(a) Residence, No. Madison near Sue City Mo (If nonresident, give city or town and State)  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

|   |   |  |
|---|---|--|
| 3. SEX<br><u>F</u>  | 4. COLOR OR RACE<br><u>W</u>  | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>Single</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF<br><u>Single</u> |   |  |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 19-1866</u>                    |   |  |
| 7. AGE  | YEARS<br><u>73</u>  | MONTHS<br><u>5</u>   |
|   | DAYS<br><u>22</u>   | IF LESS than 1 day, ..... hrs. or ..... min.                               |
| OCCUPATION  | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.<br><u>Housekeeper</u>       |  |
|   | 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.<br><u>Self</u>                       |  |
|   | 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation |  |

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 11 1940

22. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1939 to Feb. 11 1940.  
I last saw her alive on Feb. 11 1940. Death is said to have occurred on the date stated above, at 11 P m.  
The principal cause of death and related causes of importance were as follows:  
Chronic Interstitial Nephritis Hememic Anemia Date of onset

Other contributory causes of importance: 10/1

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

FATHER  
13. NAME James R. Davis  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER  
15. MAIDEN NAME Margaret Colman  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Ethel J Wolf, Lablata Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Lablata DATE Feb 13 1940

19. UNDERTAKER (ADDRESS) D. J. Christie, Lablata Mo

20. FILED Feb 12 1940 Louise Johnson Registrar.

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) C. H. Buckley M. D.  
(Address) La Plata 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.

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

RECEIVED  
MAR 4 1940

RECEIVED

District Health Officer No. 10

District File Number 3-40-463

Date Filed MAR 4 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7308

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 532

Primary Registration District No. 3712

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town Johannston  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

Nancy Ann Davis

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Feb 12 1940 (b) Louise Johnson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon  
(c) City or town Rural  
(If outside city or town limits write "RURAL")  
(d) Street No. Near Sue City  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 11  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. H. Buschley (M. D. or other) \_\_\_\_\_

Address La Plata, Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

