

19017

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

JUN 6 1940 569

Primary Registration District No. 5765

Registrar's No. 74

67

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

1. PLACE OF DEATH:

(a) County Mississippi, Miss

(b) City or town Myatt, Mo

(c) Name of hospital or institution: Shio

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miss

(c) City or town Myatt, Mo

(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Burier Davis 120

8. (b) If veteran, name war no 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27<sup>th</sup>

year 4 hour 9:20 minute 0 P. M.

4. Sex m 5. Color or race wh 6. (a) Single, widowed, married, divorced Baby

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

7. Birth date of deceased: May 27 1940

(Month) (Day) (Year)

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.

8. AGE:

Years	Months	Days	If less than one day
<u>Bene Baby</u>	<u>Bene Baby</u>	<u>6</u>	<u>hr. 0 min.</u>

Immediate cause of death Premature baby, Bene Baby

they had to have

9. Birthplace Myatt, Mo 0

(City, town, or county) (State or foreign country)

10. Usual occupation Infant

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

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

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

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

MOTHER FATHER { 12. Name John Alvin Davis

13. Birthplace Johnson Co, Mo

(City, town, or county) (State or foreign country)

14. Maiden name Erne Bradley

15. Birthplace Myatt, Mo

(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant John Alvin Davis

(b) Address Myatt, Mo

17. (a) Burial (b) Date thereof 5-28-40

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Out Myatt, Mo

18. (a) Signature of funeral director None Private

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

19. (a) 5-28-40 (b) F. J. Vernon

(Date received local registrar) (Registrar's signature)

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? 745

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury 5

23. Signature Vera Gellmore (M.D. or other) \_\_\_\_\_

Address Myatt, Mo Date signed \_\_\_\_\_

RECEIVED

District Health Officer No. 2,

District File Number 640-109

Date Filed 6/5/40

---

---

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19017

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 369

Primary Registration District No. 3765-

Registrar's No.

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

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town  
(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 Burien Davis  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex m 5. Color or race wh  
6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife  
6. (c) Age of husband, or wife, if alive  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 hr min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER  
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director  
(b) Address

19. (a) 7-9-40 (Date received local registrar) (b) F. A. Verma (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State (b) County  
(c) City or town (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 21  
year hour minute M.  
21. I hereby certify that I attended the deceased from 19 to 19;  
that I last saw h. 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  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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) (f) Means of injury  
23. Signature Frank A. Verma (M.D. or other)  
Address Charleston Mo Date signed

SUPPLEMENTAL COPY

S-19017