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

22330

Do not use this space.

1. PLACE OF DEATH
(a) County Montgomery — Registration District No. 595
(b) Township — Primary Registration District No. 435 — Registered No. 12
(c) City or Hillsville Mo — (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 (20) Dewey Davis
(a) Residence, No. about one year St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept. 1899
7. AGE: YEARS 44 — MONTHS 9 — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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. Labor
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): Miami Mo

FATHER
13. NAME: Henry Davis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Miami Mo

MOTHER
15. MAIDEN NAME: Hebie Davis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't know

17. INFORMANT (ADDRESS): Mary Davis, 314 Mt Baine Ave.
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Calvary Cem. DATE: 7-2, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS): F B Wells, Hillsville Mo 525
20. FILED: July 2, 1940 Mrs Mike McDermott, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 6-30-, 1940
22. I HEREBY CERTIFY That I attended deceased from June 30, 1940 to June 30, 1940
I last saw him alive on June 30, 1940. Death is said to have occurred on the date stated above, at 12 M m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis, and myocardial degeneration	3
93 C	

Other contributory causes of importance:

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? No
If so, specify
(Signed) J. J. Boland, M. D.
(Address) Hillsville Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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.

I X16605

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 compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22330

Registration District No. 595 Primary Registration District No. 4383 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Wellsville Mo
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Dewey Davis
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Sept (Month) 1899 (Day) (Year)
8. AGE: Years 40 Months 9 Days — If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) July 2 1948 (b) Mrs Mike McDermott
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 30 year 1940 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 — Duration
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) (e) Means of injury
23. Signature D J Byland (M. D. or other)
Address Wellsville Mo Date signed

SUPPLEMENTARY