

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

Do not use this space.

29514

FILED SEP 25 1940

1. PLACE OF DEATH
 County St. Francis Registration District No. 771
 Township 2 Primary Registration District No. 4467
 City Bismarck (No. _____) St. _____ Ward _____

2. FULL NAME Sarah Belle Davis
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Jerry J. Davis</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 25 1860</u>		
7. AGE YEARS <u>79</u>	MONTHS <u>10</u>	DAYS <u>13</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>✓</u>		
10. Date deceased last worked at this occupation (month and year) <u>✓</u>		11. Total time (years) spent in this occupation <u>✓</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clay City Mo.</u>		
13. NAME <u>David M. Shield</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown Mo.</u>		
15. MAIDEN NAME <u>unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
17. INFORMANT <u>C. E. Davis</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Bismarck</u> DATE <u>8-10 1940</u>		
19. UNDERTAKER (ADDRESS) <u>White & Sons Bismarck Mo.</u>		
20. FILED <u>Aug 9 1940</u> <u>E. W. Gale</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-8 - 1940

22. I HEREBY CERTIFY, That I attended deceased from 8-1 1940 to 8-8 1940
 I last saw her alive on 8-8 1940 Death is said to have occurred on the date stated above, at 4:50 p.m.
 The principal cause of death and related causes of importance were as follows:
Apoplexy
Sensitivity
 Other contributory causes of importance:
None

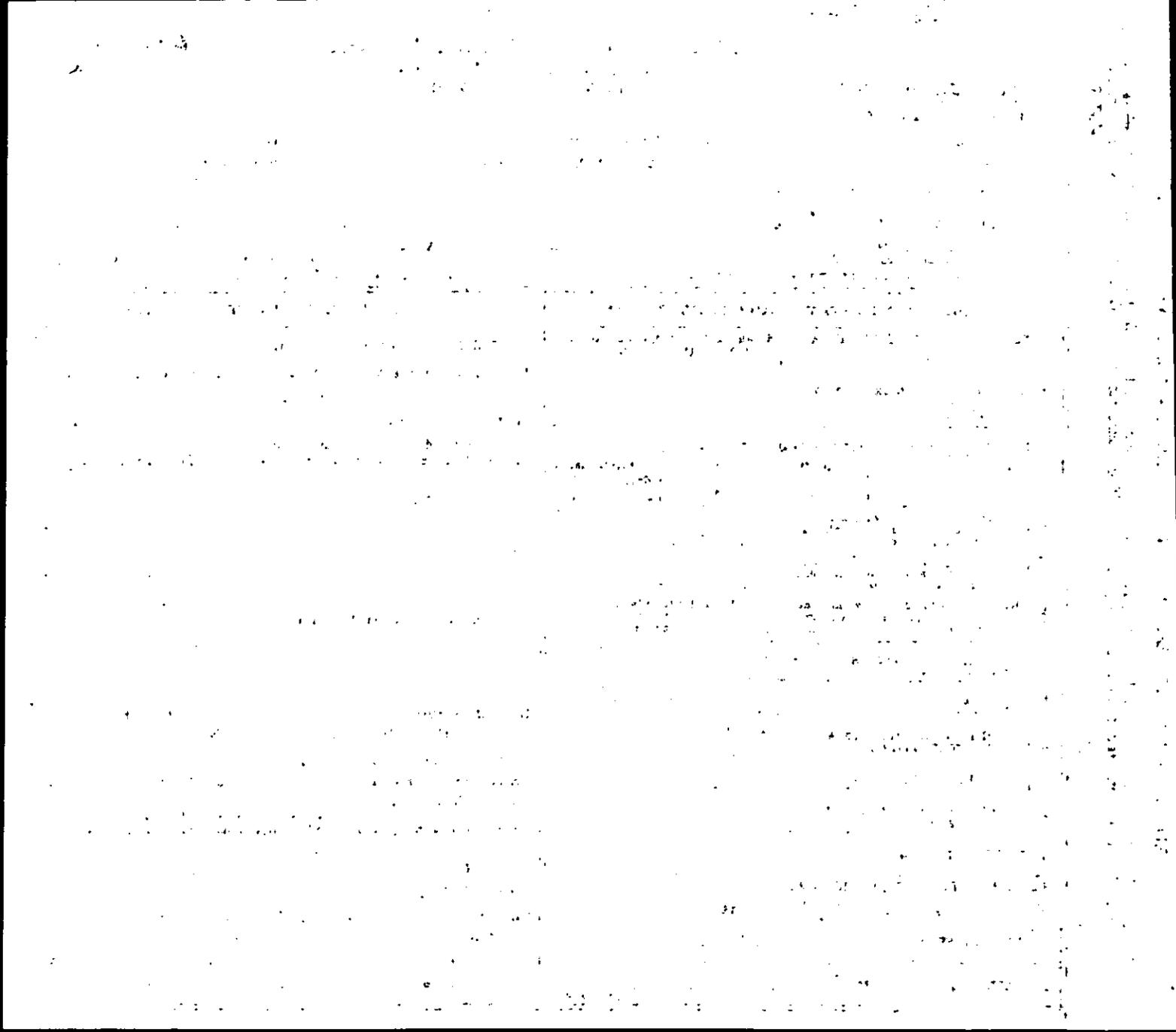
Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) James W. Keuffman, M. D.
 (Address) Bismarck Mo

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!



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 298-14

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 771

Primary Registration District No. 4462

Registrar's No.

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

1. PLACE OF DEATH

(a) County St Francois
(b) City or town Bismarck
(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
In this community.....
years, months or days)

3. (a) PRINT FULL NAME

Sarah Belle 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 wid

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 79 Months 10 Days 13
If less than one day, 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..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....
(b) Address.....

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

(Burial, cremation, or removal)

(c) Place: burial or cremation.....

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

19. (a) 8-9-1940 (b) L. W. Gale M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francois

(c) City or town Bismarck
(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 8 day 8
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 James W. Huffman (M. D. or other)

Address Bismarck Mo Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

