

Registration District No. **1050**Primary Registration District No. **5635**Registrar's No. **6**

1. PLACE OF DEATH:

(a) County **Lawrence**
 (b) City or town **Pierce City Rural**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **M.A. DeLoe**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Life time** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Naomi Florene Davis**3. (b) If veteran, name war _____ 3. (c) Social Security No. **X**4. Sex **F** 5. Color or race **B** 6. (a) Single, widowed, married, divorced **single**6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **27** years7. Birth date of deceased **Aug. 27** (Month) (Day) (Year)8. AGE: Years **23** Months **2** Days **4** If less than one day hr. _____ min. _____9. Birthplace **Wichita Kansas** (City, town, or county) (State or foreign country)10. Usual occupation **Housework**

11. Industry or business _____

12. Name **C.O. Davis**13. Birthplace **Fairview Mo.** (City, town, or county) (State or foreign country)14. Maiden name **Frances Davis** (City, town, or county) (State or foreign country)15. Birthplace **Newton Co.** (City, town, or county) (State or foreign country)16. (a) Informant **C.O. Davis**(b) Address **Pierce City R.R. 2**17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11/3/40** (Month) (Day) (Year)(c) Place: burial or cremation **Jolly Cem. 427**18. (a) Signature of funeral director **Thompson**(b) Address **Pierce City Mo.**19. (a) **11-3-1940** (Date received local registrar) (b) **Tree Woods** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lawrence**
 (c) City or town **Pierce City (Rural)** (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 **11** day **2** year **1940** hour **6** minute **15** M.21. I hereby certify that I attended the deceased from **Oct 15th** to **Nov 2**, 19**40**, that I last saw her alive on **Nov 1st**, 19**40**, and that death occurred on the date and hour stated above.Immediate cause of death **Melanoma of right leg - advancing into metastatic melanoma of brain**Due to **Removal of Birthmark**Other conditions **50**Major findings: Of operations **None performed**

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 _____

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

23. Signature **Dr. Chas. D. Dugard** (M. D. or other) **D.O.**Address **Pierce City** Date signed **Nov 3, 1940**

RECEIVED

District Health Officer No. 6,

District File Number 1240-2953

Date Filed DEC 6 1911

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed

Arthur O. Hennepin

Licensed Embalmer No. 3822

P. O. Address Perse City Pa

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 39063

Registration District No. 1050

Primary Registration District No. 3635

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Laurence
(b) City or town St. Clairant, 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
In this community _____
years, months or days)

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 Naomi Florence Davis

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

4. Sex F 5. Color or race W 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 _____ (Month) (Day) (Year)

8. AGE: Years 23 Months 2 Days 4 If less than one day _____ min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace Jarvis, Barry Co. (Mo.) (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace Newton Co. (Mo.) (City, town, or county) (State or foreign country)

16. (a) Informant C. O. DAVIS
(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) 11-3-1940 (b) Rice Woods
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2
year 1941 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?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Chas Baumgardner M.D. (M.D. or other) _____

Address Pierceland, 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

SUPPLEMENTARY

S-39063 1940