o. 2
13-40
7-39
23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 23 1942

8026

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8026

Registration District No. 8236 Primary Registration District No. 6098A Registrar's No. 12

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

1. PLACE OF DEATH: (a) County Stoddard (b) City or town Power Liberty Twp
(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 Whole life

2. USUAL RESIDENCE OF DECEASED: (a) State Missouri (b) County Stoddard
(c) City or town Power
(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 Leone Davis

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female 5. Color or race White 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 Jan. (Month) 6 (Day) 1924 (Year)

8. AGE: Years 18 Months 1 Days 11 If less than one day hr. — min.

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

10. Usual occupation None

11. Industry or business —

FATHER
12. Name Grover Davis
13. Birthplace Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jewel Burton
15. Birthplace Corning Ark (City, town, or county) (State or foreign country)

16. (a) Informant Jerry Davis
(b) Address R1, Bernie Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Bernie, Mo.

18. (a) Signature of funeral director Duncan Funeral Home
(b) Address Bernie, Mo

19. (a) 3-9-1942 (Date received local registrar) (b) Carrie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 year 1942 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from Unknown 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 Uterine hemorrhage in convulsions — Duration

Due to Epilepsia

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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

23. Signature John W. Wilson (M. D.)
Address Bloomfield Mo. Date signed 3/26/42

1133 (Licensed Embalmer's Statement on Reverse Side) County Doctor

RECEIVED
District Health Office No. 2,
District File Number 342786-4
Date Filed 31/12/42

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8024

Registration District No. 836 Primary Registration District No. 6098A Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Dowe
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Leone 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased Jan (Month) 6 (Day) 1923 (Year)
8. AGE: Years 18 Months Days 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 (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 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.

	Duration
Immediate cause of death Uterine Convulsions	
Due to Epilepsy	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature John Hinton (M. D. or other)
Address Bloomfield Mo Date signed 4/9/42
County Coroner

SUPPLEMENTARY

85