LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

APR 1 1926

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

5361

1. PLACE OF DEATH
County Monroe Registration District No. 587 File No.
Township Woodlawn Primary Registration District No. 1585 Registered No. 1
City (No. St. Ward)

2. FULL NAME Fannie Alice Davit
(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) married

5A. IF ~~MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Selden Davit

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/28-1884

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
41	9	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Monroe Co. Mo.

PARENTS
10. NAME OF FATHER Robert Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Lodwerska Carter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Virginia

14. INFORMANT Selden Davit
(Address) Madison Mo

15. FILED 2/28 1926 F Weddington
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/27 1926

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19...., that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 11 30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

ISA ~~Cancer~~ &
Tuberculosis of lungs
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

2nd (Signed) Dr E Baker, M.D
2/27, 1926 (Address) Madison Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Alexander
DATE OF BURIAL 2/28 1926

20. UNDERTAKER Fred A. Thompson
ADDRESS Madison Mo

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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and Sta

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased from ...
.....,19....., to .....
that I last saw h..... alive on.....,19.....
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mo

CONTRIBUTORY.....
(SECONDARY)

.....(duration) .....yrs. .....mo

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT C
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, S
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF

20. UNDERTAKER	ADDRESS