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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

41335

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 12010

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

City St Louis Mo (No. ISOLATION HOSPITAL St. ..... Ward)

2. FULL NAME Joe Dale Davis (Davis)

(a) Residence. No. 1721 Missouri St., 22 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-7-22

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	8	7	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(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) Mo.

PARENTS

10. NAME OF FATHER Maurice Davis

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

12. MAIDEN NAME OF MOTHER Dora Miller

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

14. INFORMANT Joe Laffler
(Address) ISOLATION HOSPITAL

15. FILED [illegible] 27, 19[illegible] Max C. Harvey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-23 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1930, to Dec 23, 1930 that I last saw him alive on Dec 23, 1930 and that death occurred, on the date stated above, at 10 25 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Scarlet Fever

8

10 8 (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Findings

(Signed) L. F. Rompare M. D.

, 19 (Address) ISOLATION HOSPITAL

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Mathews	12/26 1930
20. UNDERTAKER	ADDRESS
McLaughlin	1631 Mo.